



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Connecticut**

**Application for 2009
Annual Report for 2007**



Document Generation Date: Sunday, September 21, 2008

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary	6
III. State Overview	9
A. Overview.....	9
B. Agency Capacity.....	23
C. Organizational Structure.....	33
D. Other MCH Capacity	36
E. State Agency Coordination.....	39
F. Health Systems Capacity Indicators	46
Health Systems Capacity Indicator 01:	46
Health Systems Capacity Indicator 02:	47
Health Systems Capacity Indicator 03:	48
Health Systems Capacity Indicator 04:	48
Health Systems Capacity Indicator 07A:	49
Health Systems Capacity Indicator 07B:	50
Health Systems Capacity Indicator 08:	50
Health Systems Capacity Indicator 05A:	51
Health Systems Capacity Indicator 05B:	51
Health Systems Capacity Indicator 05C:	52
Health Systems Capacity Indicator 05D:	52
Health Systems Capacity Indicator 06A:	53
Health Systems Capacity Indicator 06B:	53
Health Systems Capacity Indicator 06C:	53
Health Systems Capacity Indicator 09A:	54
Health Systems Capacity Indicator 09B:	55
IV. Priorities, Performance and Program Activities	56
A. Background and Overview	56
B. State Priorities	57
C. National Performance Measures.....	62
Performance Measure 01:	62
Performance Measure 02:	64
Performance Measure 03:	68
Performance Measure 04:	70
Performance Measure 05:	73
Performance Measure 06:	76
Performance Measure 07:	79
Performance Measure 08:	82
Performance Measure 09:	84
Performance Measure 10:	87
Performance Measure 11:	90
Performance Measure 12:	93
Performance Measure 13:	96
Performance Measure 14:	98
Performance Measure 15:	101
Performance Measure 16:	103
Performance Measure 17:	105
Performance Measure 18:	107

D. State Performance Measures.....	110
State Performance Measure 1:	110
State Performance Measure 2:	112
State Performance Measure 3:	114
State Performance Measure 4:	117
State Performance Measure 5:	119
State Performance Measure 6:	122
State Performance Measure 7:	125
State Performance Measure 8:	127
E. Health Status Indicators	129
F. Other Program Activities	131
G. Technical Assistance	133
V. Budget Narrative	135
A. Expenditures.....	135
B. Budget	135
VI. Reporting Forms-General Information	137
VII. Performance and Outcome Measure Detail Sheets	137
VIII. Glossary	137
IX. Technical Note	137
X. Appendices and State Supporting documents.....	137
A. Needs Assessment.....	137
B. All Reporting Forms.....	137
C. Organizational Charts and All Other State Supporting Documents	137
D. Annual Report Data.....	137

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Joseph Teal
Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Historically, the DPH conducted public hearings to solicit public input into the MCHBG. This method of input was for the most part unsuccessful, and last year we conducted community-based focus groups which proved to be more advantageous.

This year, the DPH solicited public input using a number of methods: (1) focus groups were conducted; (2) family readers were recruited; (3) a Family Experience Workgroup was convened; and (4) DPH website posting.

Focus groups: with the assistance of the federal New Haven Healthy Start Program, we convened a focus group of 24 individuals, 3 of whom were men, in New Haven CT. The focus group was facilitated by the Title V Director, and included the use of a written questionnaire to ensure both qualitative and quantitative data were gathered. A snapshot of the health care services that respondents stated they needed but are unable to obtain included: (1) children's mental health, (2) transportation, and (3) dental. Participants were provided with information in response to the questions they asked regarding access to services and were all reminded to call the MCH Information and Referral Services, 2-1-1 if they ever need information on services in the state.

Family Readers: The DPH Family Advocate recruited four families to review the MCHBG application. An initial meeting was held to review the process, followed by a second meeting to collect information from the families regarding their response after reading the BG. The readers consisted of: a 32-year old divorced mother of two, homeowner and full-time worker with

3 jobs; a mother of 4 children and grandmother of ten, some of whom utilize SBHCs; a mother of 6, married and stay-at-home mom; and a mother who is married with 2 children, has a Master's Degree and military experience. A snapshot of the issues identified by the family readers includes: lack of affordable health insurance, lack of access to dental services, long waiting time at CHC(s), need for schools to better address exercise for children, parental input for MCHBG (suggested conducting neighborhood meetings), and mental health services for children.

Family Experience Workgroup: This workgroup is part of the Medical Home Advisory Council and was established to inform discussions to address family issues, concerns and overall experience with the CYSHCN Program on an ongoing basis. This workgroup has discussed and provided input for the CYSHCN National Performance Measures.

Website: The MCHBG was available for review on the DPH website. The public was encouraged to submit written comments, however none were received.

All participants were provided with a stipend (gift card) for their time and input.

Finally, in response to an issue raised by last year's readers, staff convened a workshop "Estate Planning: Everything You Need to Know about Special Needs Trusts and Guardianships." Sixteen individuals attended and included families with CSHCN from ages seven to young adults. The presentation was conducted by an attorney who was also a founding member of Parents Available to Help, Inc., a grassroots family organization that provides information and support for families who have CSHCN.

The complete analysis of the questionnaire and write up of the family readers is located in the Appendix.

An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ 1. Strengthen Data Collection and Reporting

The database migration process became a major DPH focus. The Newborn Screening's Child Health Profile (CHP) database was identified as a priority resulting in documentation of the business needs of the Newborn Screening System. This took priority over completing the linkage of the death records.

The electronic reporting system, CHIERS, was updated to include the 2006 birth data; added new confidence interval option (from MICA) to the CT CHIERS version; and the web page was modified to meet the CT DoIT standard.

Selected findings from the linked Birth-Medicaid-WIC data analysis indicated that enrollment in WIC at least 12 weeks before delivery was associated with reduced risk of delivering a LBW infant. This information was presented at a statewide health disparities meeting and included in several grant applications.

Information from CT's PRATS data was disseminated to a wide audience including: sharing a copy of the PRATS Round 2 report with Idaho; responding to the Hartford Health Department (HHD) to integrate PRATS data into a Preconception Care plan for the City of Hartford; incorporating selected data into several grant proposals and a statewide LBW strategic plan; including as part of a presentation at a statewide health disparities meeting; providing to the HHD to support their Federal Healthy Start application; sharing with the MCH Workgroup under the Medicaid Managed Care Council QA Subcommittee; and to the Governor's Early Childhood Cabinet's "Ready by Five, Fine by Nine" initiative.

2. Establish Collaborative Relations at the State/Local Level

DPH will work with University of Connecticut on the statewide surveillance for FIMR including partnering with the cities of Bridgeport and Waterbury, 2 communities with known high rates of fetal and infant deaths, who do not currently receive FIMR funding, to identify adverse birth outcome trends and create statewide fetal and infant mortality prevention and intervention.

The State Perinatal Health Advisory Committee, now part of the Infoline MCH Advisory Committee, continues to meet. DPH supported DSS for a Region I Fatherhood Conference and use of MCHBG TA funds for Real Dads Forever to develop a curriculum for fathers.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline to implement a referral/coordination of services system to assess and refer CYSHCN and their families to the new system.

DPH maintained public/private partnerships with other organizations that serve CYSHCN and their families. The Medical Home Advisory Council began to implement and evaluate the long-term comprehensive plan to improve the community-based system of care for CYSHCN.

3. Reduce Intentional Injuries

FHS maintains collaboration with this program and provides ad hoc support to the IPP for the developing Injury Surveillance System. Title V funds continue to be provided to support IPP activities at CT Children's Medical Center.

4. Improve Adolescent Health Status

The CT legislature allocated additional funds in FY 08 and FY 09 to enhance school based health services. Specific schools were identified to receive additional funds for medical/mental health services and for the creation of five new SBHCs. The remainder of the allocation will expand medical, mental health and dental services and mental health services at existing DPH funded SBHC sites located in priority school districts or medically underserved areas. Funds were dispersed through an RFP process for: expanding staffing and staff hours, providing services over the summer; adding dental services and creating a SBHC program for evening high school students.

5. Promote Nutrition and Exercise to Reduce Obesity

FHS will continue to partner with SBHCs to promote healthy eating and active living among students as well as with SDE and the DPH Obesity Program. SDE was unable to complete SNPAP survey due to limited staff resources. Title V funds were allocated last year for the first time to the Obesity Prevention Program.

6. Increase Access to Pre-conception Education and Parenting

DPH continues to partner with the HHD on their CDC/CityMatCH technical assistance grant to address systems of care as it relates to preconception and interconceptional care. A Region I MCH workgroup was conducted last fall to promote the Life Course perspective and its integration into Title V programs. DPH applied for HRSA's First Time Motherhood/New Parent's Initiative Grant to promote existing preconception, interconception and parenting programs for CT women and men.

7. Promote access to family support services including respite care and medical home system of care for CYSHCN

DPH continues to support and enhance the family-centered Medical Home concept in CT through the Child Health & Development Institute (CHDI) and their subcontractors, the UConn Center of Excellence in Developmental Disabilities and the Family Support Network, who provide statewide outreach and culturally competent education to pediatric PCPs and families on the concept of medical home for CYSHCN, and to link them to medical homes and family support services.

DPH provides TA for care coordination activities associated with the CT Medical Home Initiative for CYSHCN through contracts with the Hispanic Health Council, St. Mary's & Stamford Hospitals, Coordinating Council for Children in Crisis, Inc., and United Community and Family Services, Inc., to provide culturally competent care coordination services in community-based pediatric practice settings for CT families.

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and Geographic location.

Epi Unit staff continues to plan for the 3rd CT PRATS including refining the sampling plan and the addition of a second stratification variable on maternal race/ethnicity. Data from Round 3 will be used to further investigate important factors related to seeking/accessing early prenatal care.

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

FHS clerical staff assisted the Day Care Licensing Program with data entry of a backlog of reports to assure the availability of information for this performance measure. A data query was put on hold, as the Day Care Licensing database was also prioritized to be migrated. FHS staff were informed in March 2008 that the data needed for this measure would be available after the migration. //2009//

III. State Overview

A. Overview

III. State Overview

A. Overview

Connecticut is a relatively small state of about 5,000 square miles and 3.5 million persons. Nearly one million of Connecticut residents are between the ages of birth to 19, amounting to 27% of the state's population (1). It is clear that the population in Connecticut has become more diverse during the past decade. The Hispanic, Asian, and AA/Black population increased an estimated 50, 68, and 13 percent respectively since the 1990 census, while the white population decreased 4%. The white non-Hispanic population comprised 83.8 percent of the Connecticut population in 1990, but that percentage dropped to 77.5 in 2000 and has remained level since then (2). See Table 1 in the document attached to this section.

/2008/ The estimated population in CT as of July 1, 2005 increased slightly by 6,693 to 3,510,207.//2008//

/2009/ The estimated population in CT as of July 1, 2006 decreased slightly by 5,398 to 3,504,809. Data shows a shift in the racial and ethnic breakdown of CT's population where Hispanic, Asian and African American populations now represent 10.9, 3.6, and 10.7 percent respectively while the White population decreased by 2.3% to 83.3%.//2009//

I. Maternal and Child Health Indicators

A. Maternal and Child Demographics

With Census 2000 information released, a more detailed picture of Connecticut and the United States became available. As the Census Bureau releases Supplemental Population Estimates, comparisons can be made on residents of Connecticut and the United States. See Tables 2 and 3 in the document attached to this section. Residents of the major cities (Bridgeport, Hartford, and New Haven) tend to be younger, unmarried, poorer, less educated, more likely to be unemployed, on public assistance, and be Hispanic or African American/Black than the state as a whole. These comparisons are in stark contrast to the demographics of some wealthy suburbs such as Darien and New Canaan.

Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole, however, there are high risk groups which experience a greater share of the burden of adverse health risks and outcomes. In Connecticut in 2002, an African American/Black baby was two and a half times more likely to die within its first year of life than a white baby, twice as likely to have late or no prenatal care, and almost twice as likely to be born with low birthweight. See Table 4 in the document attached to this section. These disparities are documented in more detail in the Needs Assessment that was completed as part of the 2006 MCHBG Application. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

B. Infant Mortality

The overall infant mortality rate has declined in the United States and Connecticut during the past two decades (3). However, African American/Black babies consistently have had higher infant mortality rates than White and Hispanic populations in Connecticut and in the U.S. From 1981 to 2003, Connecticut's infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births. However, the infant mortality rates for African Americans/Blacks in 2003 was 11.5 and substantially exceeded the rates for whites in all years from 1981 to 2003. See Figure 1 in the document attached to this section.

This gap reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birthweight. Targeting prevention programs to groups showing a high rate of low and very low

birthweight infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the nonwhite infant population in the state.

Programming within the Department of Public Health (DPH) to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods. Pre-conception interventions aimed at school-aged audiences and women of childbearing age include primary care services, targeted health education programs, and outreach and case-finding to link individuals and families to primary and preventive services. Prenatal efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers. /2008/ Infant mortality rates (IMR) continue to be higher in the African American and Hispanic population. For 2005, the provisional IMR for African Americans was 10.7 per 1,000 live births compared to 3.4 per 1,000 live births for Whites. DPH is partnering with the Hartford Health Department on their CDC/CityMatCH technical assistance grant to address systems of care as it relates to preconception and interconceptional care. A Region One MCH workshop is being planned to better understand the Life Course approach and its application to the state MCH Title V programs and policies. Application of this approach could over time impact the IMRs. DPH is collaborating with the New Haven Federal MCHB Healthy Start Program to roll out an Infant Mortality campaign targeting the African American community in June.//2008//
/2009/ IMR is higher in the African American (AA) and Hispanic population in 2006. (AAs was 14.6, 7.2 Hispanics and 4.5 for Whites). //2009//

C. Births to Teens

Teen birth rates declined dramatically during the past decade as the birth rate for teens age 15-19 dropped from 59.0 to 43.0 per 1,000 teens nationally between 1993 and 2003. In Connecticut, the rate dropped from 38.8 to 25.8 infants born per 1,000 female teens (4). An African American/Black or Hispanic baby born in CT in 2003 was approximately 4 to 5 times more likely to have a teenager as a mother than a white baby. See Figure 1 in attachment to this section. According to the National Center for Health Statistics preliminary birth data for 2003, Connecticut ranked fifth in the nation for its teen pregnancy rate for 15-19 year olds, with a rate of 25.8 births per 1,000 females ages 15-19 in comparison to the national rate of 43.0 (4). The percent of births to teens varies by race and ethnicity. The overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks. However, there remains a greater percentage of pregnancies among teens in the African American/Black and Hispanic populations when compared to white teens. See Figure 2 in the document attached to this section.

Teen pregnancy is considered a public health problem for several reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through Connecticut's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. State-sponsored specialized programs such as the Right from the Start Program serve pregnant and parenting teens. This program provides intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

/2008/ The provisional teen birth rate for 2005 was 23.3 per 1,000 teens age 15-19 years old, with the largest proportion being births to Hispanic teens (77.1) followed by African American teens (41.6). DPH is making programmatic changes to more accurately reflect the data regarding births to teens. Collaborations with JSI have been instrumental in identifying science-based teen pregnancy prevention programs. DPH has partnered with the Konopka Institute to conduct a workshop, "You've Been Framed," to help Title V programs build good will and support for delivering positive messages to youth. //2008//

/2009/ The 2006 provisional teen birth rate was 23.4 per 1,000 teens age 15-19 yrs old, with

the largest to Hispanic teens (78.1) then AA teens (46.6). The very slight increase from 2005 to 2006 is much less than that nationally.//2009//

D. Prenatal Care

Non-adequate prenatal care is a composite measure, reflecting both the time of the first prenatal visit and the number of visits. The "non-adequate" grouping includes both "inadequate" and "intermediate" care as defined in the Kessner Index of prenatal care (5). Adequacy of prenatal care has improved during the past decade. Although the gap is closing in differences in race, adequate prenatal care is less often achieved by African American/Black and Hispanic women. See Figure 3 in the document attached to this section. In 2002, 2.0 percent of CT women received late or no prenatal care in comparison to 3.6 percent nationally. Connecticut ranked one of the lowest rates of late or no prenatal care, along with the other New England states (6).

The Department has tried to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are appropriately referred for early prenatal care, in keeping with established protocols.

/2008/ In 2005, the provisional percent of non-adequate prenatal care in CT was 19.8%. Non-Hispanic African American women were 1.8 times more likely to receive non-adequate prenatal care than non-Hispanic White women (28.9% among non-Hispanic African American women versus 16% among non-Hispanic White women). Hispanic women were 1.7 time more likely to receive non-adequate prenatal care (27.3%).//2008/

/2009/ The 2006 % non-adequate prenatal care was 19.9%. Non-Hispanic AA & Hispanic women were 1.7 times more likely to receive non-adequate prenatal care than non-Hispanic White women.//2009//

E. Low Birthweight

Low birthweight (under 2,500 grams) is a major cause of infant mortality and long-term health problems. The impact of low birthweight on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when low birthweight infants are about 40 times more likely than normal weight infants to die. For very low birthweight infants (less than 1,500 grams or 3 lbs. 3 oz), the risk of death is 200 times higher than among normal-weight newborns. See Figure 4 in the document attached to this section. In 2003, 7.5 percent of births had low birthweight in Connecticut in comparison to 7.9 percent nationally (4). While there have been improvements in the infant mortality rates, low birthweight has remained relatively stable for the past two decades. Low birthweight is more common among infants of African American/Black and Hispanic mothers. Likewise, twins and multiple births have a higher frequency of low and very low birthweights compared with singleton newborns.

/2008/ In 2005, the provisional low birth weight percent in CT was 8.0%. Low birth weight remains highest among the African American mothers at 13.7% while Hispanic mothers have a percent close to the CT percent (8.3%).//2008//

/2009/ The 2006 LBW % in CT was 8.2%. LBW remains highest among the AAs at 12.7% while Hispanics have a % slightly higher than CT(8.9%).//2009//

F. Other MCH Indicators

The positive maternal and infant health effects of breastfeeding have been well documented. The estimated rate of breastfeeding in Connecticut has improved from 68.7% to 69.3%, just shy of the state's goal (69.5%). Generally, the rate of women in Connecticut breastfeeding while in the hospital is 73.2% and at 6 months the rate is 28.3% (7). Thus, the rate of initiation of breastfeeding among all women has improved (as indicated by hospital rates) but declines rapidly by six months. The role of the Title V program has been to promote breastfeeding as a social norm in the state. Other infrastructure building activities included conducting a statewide needs assessment of the breastfeeding practices of Black and African American women to determine how best to promote and support breastfeeding in this population, which breastfeeds at a lower rate than other groups.

Although pregnant women in CT were less likely to smoke than their counterparts nationwide (see the CT Needs Assessment), smoking during pregnancy remains a public health issue. The role of the Title V program is multi-fold and includes functioning as a partner with the DPH's Tobacco Control Program to address smoking cessation during pregnancy, as well as with federal and regional level initiatives (i.e. -- National Partnership to Help Pregnant Smokers Quit), which can be implemented at the state level. Other infrastructure building activities including the facilitation of meetings with the state DSS and Managed Care Organizations (MCOs) to discuss reimbursement mechanisms for smoking cessation products and support services.

/2008/ The DPH has been successful in leveraging additional federal and state funds to sustain its perinatal depression activities originally funded by MCHB in 2005. The DPH continues to address the need for perinatal depression screening and has instituted a pilot, provider consultative line (staffed by mental health clinicians) for providers who screen clients for perinatal depression. Funding from the Region One Office on Women's Health (OWH) has complemented other funding streams to continue advertisements on transit buses.//2008//

/2009/ A fact sheet on perinatal depression is mailed to new CT parents.//2009//

II. Other Indicators

A. Socioeconomic Indicators in Connecticut

In Connecticut, there is a disparity between the wealthiest and poorest citizens. While Connecticut is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of \$55,004, Connecticut was ranked fifth in the nation (8) in 2003. Within Connecticut, however, the median family income and other characteristics recorded in the 2000 Census vary within the State and its large cities, and New York suburbs. While many children within Connecticut lived in affluent homes, nearly 86,000 lived below the poverty level (9). In Hartford, over 40% of the children were estimated to be living in poverty (10), a figure surpassed only by one other city in the nation with a population over 100,000. Despite its relative wealth, and with recent decreases in state revenues, efficiency is paramount to reversing child health disparities within the state. The economic disparity experienced by the cities is mirrored in differing maternal and child health statistics. See Table 5 in the document attached to this section.

The economic recession that began mid year 2000 appears to have ended, recovering from a downturn in the economy since the terrorist attacks of September 11, 2001. Between September 2003 and March 2005, Connecticut recovered 28,000 of the 61,000 jobs lost since 2000 (11). The state's economy is supported predominantly by services, manufacturing, and retail trade industries. Unemployment in Connecticut has risen to 5.3 percent in comparison to 5.1 percent nationally (12).

/2008/ CT's labor force is expected to grow by 8,000 workers from 2006 to 2007, with unemployment falling to 4.4 percent compared to 4.5 percent nationally.//2008//

/2009/ CT's labor force is expected to grow. CT's residents had the highest per capita personal income of \$50,787(2006) that was 37% higher than the national average of \$36,629. In contract to this affluent scenario, CT is among the states with the worst racial disparities in the nation for assets. The state budget is currently operating with a \$150 million deficit.//2009//

B. Health Care Delivery Environment in Connecticut

Connecticut does not function on a county-based system for the delivery of public health services to its residents. Direct health care services are delivered to residents through a wide range of providers including, but not limited to, school based health centers, community health centers, outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services

ranging from intravenous infusion of medications to physical therapy. The licensure or certification of health care facilities and health care professionals guides promotion of high quality health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The Healthy Start Program is a collaboration between the State Departments of Social Services (DSS) and Public Health. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low income families in CT. The DSS contracts with 5 agencies statewide, which in turn contract with other community based providers to provide case management services to pregnant women and their children up to age three. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all twenty-nine birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

Connecticut is part of the national trend in the delivery of health care services in which managed care has expanded and has become the dominant financing mechanism. The Connecticut care delivery system is challenged by managed care and the lack of sufficient services for the uninsured. These methods of financing affect not only the availability and delivery of services, but also the quality of patient outcomes. Hospital mergers have occurred in Connecticut and lengths of stays in hospitals have decreased, as has the rate of hospitalizations (13).

/2008/ To date, seven "Minute Clinics" have been established at local CVS pharmacies. These clinics are staffed with licensed Nurse Practitioners and Physician Assistants and serve clients ages 18 months of age and older.//2008//

/2009/The number of Minute or Convenient Care Clinics has risen to 16./2009//

/2008/Legislation is currently pending that would expand the eligibility for the state Healthy Start Program from <185% of the FPL to <250% of the FPL. This expansion would increase access to case management services for pregnant women.//2008//

/2009/ Healthy Start eligibility is now 250% of the FPL./2009//

C. Safety Net Providers

Safety Net Providers comprise the system of care that addresses the needs of those individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural, linguistic, etc. One of the primary groups targeted by safety net providers are the uninsured. In Connecticut, the safety net provider system is comprised of Community Health Centers, School Based Health Centers, Visiting Nurse Associations, Local Health Department and Family Planning Clinics. Maintaining and supporting the safety net providers is a priority for the State. With increasing financial challenges, CT's focus is to avoid the erosion of this health care delivery system. During the 2005 legislative session, the Torrington Community Health Center, an FQHC look-alike, was allocated state funding and the remaining CHCs were given a small cost of living adjustment.

/2008/ During the 2007 legislative session, United Community and Family Services, Inc. in Norwich was given \$200,000 to provide community health center services in addition to the oral health services already funded.

The CHCs and SBHCs received COLAs on state funding. State bonding dollars have been made available to CHCs and SBHCs to continue to build their capacity as a safety net provider. SBHCs have recently received \$1.0 million in bonding funds for expansion of this safety net provider system.

During the past year there has been a merger between New Britain General Hospital and Bradley Memorial Hospital. Both are now under the auspices of The Hospital of Central Connecticut.

Both campuses are still providing services to CT residents.//2008//
/2009/ CHCs & SBHCs will receive additional state funding in both 2008 and 2009.//2009//

D. Health Insurance

HUSKY (Healthcare for Uninsured Kids and Youth) is Connecticut's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, Connecticut renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. Both HUSKY A and B are managed care programs, administered through the Department of Social Services and private health plans. HUSKY A covers pregnant women and children in families with income under 185% of the federal poverty level. HUSKY A provides preventive pediatric care for all medically necessary services. It also covers parents and relative caregivers in families with income under 100% of federal poverty. There are 310,878 persons, including 218,420 children under 19 in HUSKY A as of May 2005. The basic HUSKY package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, outpatient surgical facility services, mental health and substance abuse services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams, and dental care (14).

/2008/ As of July 1, 2006 the FPL for HUSKY A coverage for parents and caretaker relatives was increased from 100% to 150%. There are 298,145 persons, including 207,323 children less than 19 years of age in HUSKY as of May 2007.//2008//

/2009/ The FPL for HUSKY A coverage is now 185% FPL. HUSKY has 296,484 persons, with 206,024 children.//2009//

HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,640 children under 19 in HUSKY B as of May 2005 (15). As part of HUSKY B, HUSKY Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs. Community-based mental health and substance abuse services to children and youth with intensive behavioral health needs are also offered under HUSKY Plus.

/2008/ HUSKY B enrollment increased slightly to 17,181 as of May 2007.//2008//

/2009/ As of May 2008, HUSKY B enrollment was 16,276.//2009//

In a January 2005 review of 2003 HUSKY data, the Connecticut Voices for Children found that just over half of the children covered by HUSKY received well-child care in 2003, with the utilization rates being the lowest among older adolescents (aged 16-19 years) (16). Utilization was lower for dental care, with only 47% of enrolled children having any dental care in 2003. While there have been improvements in dental care utilization rates during the past few years, fewer than half of enrolled children who are eligible for preventive dental care services through HUSKY A actually received these services (17).

There have been changes that limit eligibility or enrollment. On July 1, 2005 families now only receive Transitional Family Assistance (TFA) for one year rather than two years. As of July 1, 2005 new and increased premiums will be imposed on children in HUSKY B. Also there is elimination of self-declaration of income mandating that applications received after July 1, 2005 show documentation of income. Fortunately there are changes that improve eligibility and enrollment, presumptive eligibility for HUSKY A children is being restored and now pregnant women experience expedited eligibility when enrolling in HUSKY A. Another improvement is that DSS is implementing increased income guidelines for parents and caretaker relatives with incomes between 100% and 150% of the federal poverty level effective July 1, 2005.

/2008// Effective July 1, 2006, families are again allowed to self-declare unless the declared

income is questionable for the applicants are self employed.//2008//

Connecticut Voices for Children released a report on Births to Mothers in HUSKY A (18). In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born. Compared to other mothers who gave birth that year, mothers who were enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% vs. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v.7%) or Hispanic (32% vs. 12% of other births). /2008// Compared to all other babies in CT, rates for low birth weight, preterm and teen births were higher for babies born to mothers covered by HUSKY A and fee for service Medicaid.//2008//

Health insurance is an important component of access to health care. People without health insurance are less likely to receive the basic health care services that the insured receive. In some cities and towns, HUSKY A covered a far greater proportion of pregnancies. In these communities, the importance of HUSKY A for improving maternal health and birth outcomes cannot be overstated. The collaborative efforts of HUSKY, prenatal care providers, community-based organizations, and other Title V funded programs are essential for ensuring that women become pregnant when they chose to, begin pregnancy in good health, begin prenatal care early, and obtain risk-appropriate high quality prenatal care and social support services throughout pregnancy (18).

As the Title V agency in Connecticut, DPH has contributed policy guidance and technical assistance to the HUSKY program by:

- Enhancing enrollment in HUSKY by participating in the Covering Connecticut's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, Benova, and Infoline).
 - Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications that will support access to comprehensive care for children and youth.
 - Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care access under Early Periodic Screening and diagnostic and Treatment Services.
 - Working with State Commission on Children, HUSKY and other Connecticut key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs.
 - Working with Local Health Departments and Immigrant health to improve health status of the Connecticut residence.
 - Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY as a way of filling the gaps in care.
 - Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, School Based Health Centers (SBHC), Community Health Centers, Family support council, and other essential community providers and Title V funded programs, (including an MOU with DSS regarding these linkages).
 - Facilitating the process by which School Based Health Centers (SBHC) are named as the only essential community providers in the DSS waiver application, resulting in all SBHCs having contracts with all managed care plans for Husky A and B.
 - Supporting Community Health Centers/Connecticut Primary Care Association and SBHCs in their efforts to receive statewide outreach grants for Husky B.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment.
- Identifying and developing needed enabling services through work with other providers and local health departments; and
 - Implementing quality improvement activities and evaluation.

A growing concern is the national and state trend among the Hispanic population being disproportionately underinsured. Although Hispanics are 10 percent of Connecticut's total population, they constitute 40 percent of its uninsured. Hispanics are five and a half times more likely to be uninsured as persons from all other ethnic or racial groups. This result reflects a national phenomenon. Hispanics are significantly less likely than non-Hispanics to have health coverage, to have a regular health care provider, and to receive regular preventative care and screenings (19).

/2008 The legislature is currently reviewing a number of proposals for universal health care for CT adults and children. There are an estimated 347,000- 407,000 uninsured adults in the state. \$1.1 million dollars in state funds were allocated to expand outreach efforts for children into the HUSKYProgram.//2008//

/2009/ The Charter Oak Plan was implemented. This is a voluntary health insurance program for adults.//2009//

E. Racial and Ethnic Disparities

Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community. When reviewing Connecticut's maternal and child health indicators, racial and ethnic disparities are quite evident. According to the "Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care" (20), a multi-level strategy must be employed to address the potential causes of racial/ethnic disparities. In CT some of the strategies have included: 1. Improving the number and capacity of providers in underserved communities by continuing to function as a liaison in the recruitment and retention of primary care health professionals. This particular activity is carried out by the Primary Care Office within the DPH and by working collaboratively with the CT Primary Care Association. 2. Increasing the knowledge base on causes and intervention to reduce disparities by collecting and analyzing data on health care practices and use across racial and ethnic groups. In a study of Latina adolescent women in CT who were pregnant, they all reported that their pregnancy was "accidental" and that if they thought they would have become pregnant they would have "delayed sexual activity" (21). The DPH is also in the process of finalizing a study on the breastfeeding practices of African American/Black women. CT's PRAMs-like study or the Pregnancy Risk Assessment Tracking Survey (PRATS) data is currently being weighted and should provide additional racial and ethnic specific MCH data. 3. The re-establishment of the DPH's Office of Multicultural Health in raising public and provider awareness of racial/ethnic disparities in health care. The Office is responsible for improving the health of all state residents by eliminating differences in disease, disability, and death rates among ethnic, racial and cultural populations. The office may provide grants for culturally appropriate health education demonstration projects and apply for, accept, and spend public and private funds for these projects. It also may recommend policies, procedures, activities and resource allocations to improve health among the state's racial, ethnic, and cultural populations.

The Connecticut Health Foundation (CHF) (<http://www.cthealth.org>) is the state's largest independent, non-profit grant-making foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. After meeting with state agencies, community leaders, and health care professionals, the Foundation selected 3 program areas to focus its resources: Improving Access to Children's Mental Health Services; Reducing Racial and Ethnic Health Disparities; and Expanding Access to and Utilization of Oral Health Services.

The Foundation's Policy Panel on Racial and Ethnic Health Disparities released its final report in March, 2005 which includes state policy recommendations that begin to address health disparities. Those recommendations specific to the Department of Public Health include:

- The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of racial and ethnic populations.
- The Connecticut Office of Health Care Access and the Connecticut Department of Public Health

should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.

- The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.
- The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.
- The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure requirements.
- The State of Connecticut should allocate no less than \$2.12 million of Connecticut's State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.
- The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.

/2008/ Recent reports indicate that CT Latinos are sicker and likely to die younger than members of any other ethnic group in the state. Although Latinos represent 9% of CT's population, they account for 40% of the state's uninsured, 25% of AIDS cases and 30% of Chlamydia cases. Language barriers remain a serious problem in getting care. 44% of the adults reported that they usually or sometimes have a hard time understanding the doctor because of language issues. Among the Black/African American population, age-adjusted death and premature mortality rates of Black/African Americans Connecticut residents are significantly higher than those of the White, non-Hispanic Connecticut residents for all six leading causes of death - heart disease, cancer, unintentional injury, cerebrovascular disease, HIV, and diabetes (1999-2001 data). African Americans have 1.2 times the age-adjusted death rate of heart disease and cancer, 1.3 times the age-adjusted death rate of cerebrovascular disease (stroke), 1.4 times the age-adjusted death rate of unintentional injury, 2.6 times the age-adjusted death rate of diabetes, and 15.7 times the age-adjusted death rate of HIV compared with White, non-Hispanic Connecticut residents (Hynes, Amadeo, and Mueller 2005).

The FHS, in collaboration with the Federal New Haven Healthy Start Program will be launching a campaign to raise awareness about infant mortality in the African American community. The campaign consists of radio and television ads, as well as posters.

The Public Health Initiatives Branch has convened an internal Health Disparities workgroup; FHS staff participate on this workgroup. The purpose of this workgroup is to assess programs in the Branch that address health disparities and strategies to provide ongoing support.

The Office of Multicultural Health is active and its goals are to: (1) Promote access to health care for all racial and ethnic minority populations (2) eliminate language barriers (3) Promote cultural competence among the healthcare and public health workforce (4) Improve data collection, analysis and reporting on health disparities and (5) Develop the healthcare and public health workforce to better represent racial and ethnic minority groups. CT recently hosted the Region One Minority Health Conference that was attended by more than 600 participants.

The PCO staff, in collaboration with an internal workgroup, developed brochures in English and Spanish to promote awareness among high school students and health care professionals regarding alternative care practice settings and opportunities such as the National Health Service

Corps and the State Loan Repayment Program.

FHS staff participated in the Region One Office on Women's Health to discuss health issues identified by the Tribal Nations in the region one states. DPH will continue to foster collaborations with the Tribal Nations and will include data from this group in the next five-year MCH needs assessment. In CT, diabetes and alcoholism were identified as an outstanding health issue with Native Americans.//2008//

/2009/ Staff developed an inventory of programs that address MCH health disparities.//2009//

F. Rural Health

The Connecticut definition of rural, adopted June 2004 by the ORH Advisory Board, uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of Connecticut. Of the 169 towns in CT, there are 29 with populations of less than 7,000 (22). Specific concerns identified for rural Connecticut include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. The Primary Care Office (PCO), located in the Family Health Section has taken on a formal role in meeting with the staff of the Office of Rural Health, and PCO staff has recently been appointed to the ORH Advisory Board. The Title V program will continue to support the PCO and its collaborative efforts with the ORH and provide technical assistance to the ORH as they better assess and document the needs of the rural health community.

/2008/ The CT Office of Rural Health (CT-ORH) contracted with a local firm to identify existing available data sources, analyze and report the key health care issues impacting rural CT. The overall goal was to gain a better understanding of the health status of rural residents and develop a supporting rural health database. The survey results indicated concerns regarding transportation service in rural communities, adequate services for substance abuse, domestic violence, oral health care and mental health services. The report can be found on www.ruralhealth.org/report.//2008//

/2009/ FHS participate on the ORH Advisory Board//2009//

G. Other Vulnerable Populations

The Department has been interested in the health needs of vulnerable women and children, many of whom face barriers to care which are not addressed by the state's managed care system. These populations include the uninsured, single mothers transitioning from welfare to work, homeless mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), immigrant and undocumented populations, infants who experience delays in newborn Medicaid eligibility determinations, and providers who are not prepared to deal with the multiple social and economic problems facing many of their patients. This is especially true in areas where hospital based clinics have closed and patients are referred to private practitioners.

Incarcerated Women's Health: The role of the Title V program has been to work collaboratively with other state agencies and community based organizations to address the issues of this vulnerable population. The DPH functioned as a conduit for bringing together key state agencies to address transitioning soon-to-be-released women, from York Correctional Institute (YCI), Connecticut's only female prison, back to the community healthy. As a result of this process, the DSS designated Medicaid eligibility workers to process Medicaid applications for inmates just prior to their release date. This is a model which can be replicated in the male correctional institutions throughout the state.

/2008/ FHS Staff are working with DOC staff to develop an MOA to implement a gender responsive curriculum for both DOC staff and inmates at YCI. The Judicial Branch/Court Support Services Division (CSSD) has been awarded a Demonstration grant from the National Institute of

Corrections called the Women Offender Case Management Model. FHS has been asked to participate on the newly formed Advisory Team.//2008//

/2009/ The MOA with YCI was executed and trainings on intimate partner violence were conducted for inmates and staff at YCI. More than 350 participated and plans are underway to assess the feasibility of conducting similar trainings at halfway house and transitional housing. Staff participate on the CSSD Advisory Team.//2009//

Homelessness: The DPH contracted with an independent public health consulting firm to assess and evaluate the health care access infrastructure for the Homeless population in order to enhance their access to health services. A statewide Homeless Health Advisory group, including governmental, public/non-for-profit, private, faith based, and advocacy organizations, was formed to guide this evaluation study. This study involved needs assessment of shelters, and their health care systems/infrastructure for the homeless population, and key informant interviews. The study is completed and the role of Title V is to identify and conduct intervention strategies to promote and enhance the health status of the homeless population.

/2009/ DPH supported the survey of CT homeless people.//2009//

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The role of Title V has been to become an active participant on the New Haven Family Alliance-Male Involvement Network and the DSS' Fatherhood Initiative Council to conduct population based activities by developing and disseminating consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health.

/2008/ DPH has become an active member of the Adolescent Paternity Workgroup convened by the Consultation Center in New Haven. This workgroup is comprised of members from DCF, DSS, DOC, and community based organizations. The Department of Social Services (DSS) has received a Promoting responsible Fatherhood Grant, funded by the Administration for Children and Families (ACF) and DPH will participate on the grants Monitoring and Advisory Committee.

The DPH is collaborating with the Hartford Community Court and the Department of Social Services and will be providing a four part parenting class for adolescent fathers who pass through the judicial system. The four components include: (1) infant/toddler growth and development (2) infant nutrition (3) child safety and (4) responsible fatherhood.//2008//

/2009/ Staff promote the inclusion of men in MCH programs.//2009//

III. Health Priorities

A. MCH Priorities

In 2004, the Department invited a selected group of experts in the maternal and child health field in the State, including healthcare professionals, community advocates, and representatives from state agencies, to map out a perinatal health plan with priority goals for the State to address. This Statewide group adopted the following as a standard definition of perinatal health to guide efforts in the maternal and child health "comprehensive and integrative continuum of health care from the preconception period through the prenatal and postnatal periods. Care should be sensitive to ethnic and cultural diversity with an emphasis on the family and father involvement".

The Perinatal Advisory Group identified nine goals to address perinatal health. These goals include: 1. Reduce perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups; 2. Improve access to a continuum of health care services for underserved and/or un-served women of child bearing age; 3. Enhance and encourage male involvement in the continuum of women's health care from preconception, prenatal through postnatal periods; 4. Reduce pregnancies and poor birth outcomes among adolescents; 5. Reduce unintended pregnancies for all women; 6. Reduce recognized birth-related risk factors for children with special health care needs; 7. Improve the

state's system capacity to collect high quality maternal child health data and disseminate in a timely manner; 8. Improve access to mental health, substance abuse treatment and dental health services which can improve the overall health for pregnant and postpartum women; and 9. Improve inter-provider communication strategies regarding perinatal health care delivery. The Perinatal Advisory group will be reconvened to prioritize and provide guidance to the Title V program regarding the implementation of the nine identified goals and objectives. This statewide perinatal strategy will provide the needed structure to better address the MCH federal and new state performance measures.

/2008/ To avoid duplication of efforts and to recognize time constraints of MCH providers, the work of the State Perinatal Advisory Group will be merged with the recently reconvened MCH Infoline Advisory Group. The Infoline Advisory Group had been inactive for about 10 years and recently held its second meeting.//2008//

/2009/ A number of the goals listed above have been met.//2009//

B. CYSHCN Priorities

The Children with Special Health Care Needs program includes the priority areas specific to this population in its program design. In order to enhance CYSHCN services, the Family Health Section (FHS) within DPH has redesigned the program by requiring the Center to operate a program that is family-centered with family participation and satisfaction; performs early and continuous screenings; improves access to affordable insurance; coordinates benefits and services to improve access to care; participates in spreading and improving access to medical home and respite service; participates in developing a community-based service system of care, and promotes transition services for youth with special health care needs.

The Department has been leading the State in the implementation of the State Early Childhood and Comprehensive System's grant (SECCS). This initiative is called Early Childhood Partners (ECP) and the process brought together eight State agencies and statewide institutions, with extensive input from numerous community interests since October 2003 to create an outcome-driven Strategic Plan to support all Connecticut families to ensure that their children arrive at school healthy and ready to succeed. The strategic plan will be used as a framework for the operations of the newly established Children Cabinet by Connecticut legislators and Governor. The Plan aims at creating an integrated service system that incorporates comprehensive health services, early care and education, and family support and parent education to ensure the sound health and full development of all children. The system would provide for easy entry, clear navigation, and appropriate supports for all families and includes six priority goals for the State, which includes: 1. Every child, adolescent and pregnant woman in Connecticut will have access to comprehensive, preventive, continuous healthcare through a family-centered Medical Home; 2. All children will have access to affordable, quality early care and education programs and an effective transition to Kindergarten; 3. All parents will have access to the support and resources they need to raise healthy children; 4. Build the capacity for planning, resource allocation and monitoring of the early childhood services system through a collaborative local or regional early childhood structure for all Connecticut towns; 5. Create a state level infrastructure to guide, support, and monitor implementation of the Early Childhood Partners plan; and 6. Promote public education and public will through a broad communication and engagement strategy.

/2008/ The ECP staff has collaborated with the Children's Trust Fund to build provider capacity as it relates to identifying and referring children with developmental delays. ECP funds were leveraged to conduct 2 Ages and Stages Questionnaire (ASQ) trainings for health care provider. It is anticipated that additional trainings will be offered in the 2008 FFY.//2008//

C. Data and MCH Impact

Consistent with the HP 2010 objectives, Connecticut gives priority to MCH surveillance through such activities as Pregnancy Related Mortality Surveillance, Child Health Profile (CHP) Database, DocSite for data management of Children and Youth with Special Health Care Needs (CYSHCN), Fetal and Infant Mortality Review, and Vital Records data collection and analysis, to name a few.

The CHP is a database located in the FHS within DPH to hold information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The CHP is linked to Electronic Vital Records (EVR). The DocSite is a web-based system used by medical homes and regional medical home support centers to collect and report CYSHCN information to DPH. Emphasis is being placed on the necessity to develop better linkages among our many sources of data. All Title V activities and programs are designed to promote and protect the health of Connecticut's mothers, children and adolescents, and children with special health care needs.

Improvements to the CHP database continue. Planned enhancements include the completion of linkage of death records into the CHP database. The matching routine will link corresponding birth newborn hearing screening results; and the commencement of the linkage of the CHP database with a fourth database.

Work towards the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids), will continue in the upcoming year. DPH continues to pursue funding for full implementation of HIP-Kids from both external and internal efforts. Once funded, implementation will progress using the three-year technical strategic plan. Please see SPM 1 for more information.//2007//

/2008/ The above paragraph on the CHP database is revised to read: Improvements to the CHP database continue which advance the creation of a data warehouse as part of the HIP-Kids project. Planned enhancements include the completion of linkage of death records into the CHP database and its migration to DPH's Public Health Information Network that meets national infrastructure and security standards. The matching routine will link corresponding birth newborn hearing screening results; and the commencement of the linkage of the CHP database with a fourth database.

A presentation of the PRATS data analysis was held and attended by DPH staff and representatives from community based organizations. In order to continue to have access to PRAMS-like data, the PRATS survey will be repeated in 2009. Staff will be submitting a HRSA MCH Research Grant to continue to build our capacity to analyze and translate MCH data. The first Birth Defects Registry Report for 2001-2004 has been released and is posted on the DPH website.//2008//

/2009/ FHS is planning for a PRATS in 2009.//2009//

There is growing emphasis on the development of data systems and linkages. Staff are coordinating the Memorandum of Understanding (MOU) between DPH and DSS regarding data exchanges. The purpose of this MOU is to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data. The initial MOU included three addenda addressing the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and on Children Receiving Title V Services and Medicaid data. Linked data will be analyzed and used to guide MCH programs.

/2008/ The first addendum of the Data Sharing MOU related to the linkage of birth and Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid. This information was previously unavailable.//2008//

/2009/ Carol Stone, MCH Epidemiologist completed an analysis of the 2000 birth cohort linked with both Medicaid & WIC information. Dr. Stone presented her findings at the MCH summit "Impact of Racial & Ethnic Health Disparities on Birth Outcomes in Connecticut" on Sept. 11, 2007 (see attachments).//2009//

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs

both at the state and local levels. In fall 2004, DPH executive staff expressed goals for improved and enhanced communications between and across programs that reduces barriers to effectiveness and efficiency across programs. To address these goals, the Virtual Child Health Bureau (VCHB) was formed. The VCHB is in the process of developing a Plan to coordinate its activities. With a special emphasis on child health, the VCHB has as its mission collaborations across branches within DPH to ensure optimum health of all children in the state. Within the VCHB, an interdepartmental group of database users and managers was formed called the VCHB Data Committee. The Data Committee now seeks to find meaningful ways to share child health information broadly across the Department. Using needs identified by staff across DPH, the Data Committee drafted a set of recommendations in spring, 2005, which may help guide its progress toward this goal. These recommendations need to be discussed, adopted and implemented. Some of these recommendations complement the state MCH priorities identified for the next five years.

/2008/ A data management module for the in-patient hospitalization and ED data was created and will be placed on DPH's Public Health Information Network to facilitate the creation of data extracts for various DPH programs who have requested access to this rich secondary data source. The VCHB continues to meet on a quarterly basis and FHS staff are active members of the VCHB Cabinet and its data subcommittee.//2008//

/2009/ Staff provided the EPHI staff with in-patient hospitalization & ED data for its placement on PHIN. DPH is working to obtain in-patient hospitalization & ED data without cost. //2009//

IV. Conclusion

It is the role of Connecticut's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention, education, and the empowering of MCH populations about health and health related issues. Infrastructure building services include needs assessment, policy development, quality assurance, information systems development and management, and training that support individual, agency, and community health efforts.

The Title V Director utilizes various mechanisms to determine the importance, magnitude, value and priority of competing factors, which impact the MCH health services delivery in the State, which includes: 1. conducting ongoing statewide assessments (MCH five-year needs assessment, breastfeeding practices of African American women, bereavement services for families experiencing a fetal or infant death, Pregnancy Risk Assessment Tracking System [PRATS], Adolescent Health, Healthcare for the Homeless, CYSHCN Needs Assessment, etc.); 2. reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which includes both quantitative and qualitative information. This information is reviewed and provides valuable input into MCH programming, as well as serving as a vehicle for identifying and documenting emerging MCH issues; 3. conducting quarterly technical assistance meetings with the MCH contractors (i.e., FIMR, RFTS, etc.). This provides an additional opportunity for contractors to share information with Title V program staff and their colleagues regarding MCH issues that they are facing as community-based providers of services. Other external factors, which cannot be overlooked and impact the importance of MCH service delivery, and MCH programming have been previously discussed (economy, insurance status, legislation, etc.). The combination of the ongoing assessments, quarterly reporting data, technical assistance meetings and site visits, as well as other sources, assists the Title V Director in addressing the MCH needs and determining priorities for the State.

/2008/ Addressing health disparities within the MCH population continues to be an ongoing priority for the DPH. Overall CT's birth outcomes compare favorably, however, subgroups do not fair as well. MCH outcome data by race and ethnicity paints a picture of a much different CT. The

FHS has taken a more data driven approach to its MCH program design and implementation, which will impact programs available to those identified most in need. The MCH Director will continue to monitor CT's progress towards a Universal Health Care Plan.//2008//
/2009/ Focus was placed on using MCH data to drive new programs & initiatives. An RFP was released for the MCHBG funded case management programs for pregnant women & eligibility for was based on the distribution of selected maternal risk and birth outcomes.

Obesity prevention activities will continue to be a focus in the coming years. 25.9 % of CT high school students are either overweight or obese. Title V funding has been allocated for obesity prevention activities & will continue as funding permits.

The new Charter Oak Program implementation will be monitored. This voluntary program includes office co-pay, deductibles & other fees that may be cost-prohibitive for vulnerable populations.//2009//

An attachment is included in this section.

B. Agency Capacity

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

Sec. 4-8(1949) Qualifications, Powers and Duties of Department Head. This statute authorizes the transfer of Title V funds to the Department of Social Services (DSS).

Sec 14-100a PA 05-58(2005) Child Restraint systems. The former infant/child seat belt law was amended to address rear-facing child seats, use of booster seats, and increase the minimum age to 6 years old or 60 pounds. The injury prevention program is impacted by this statute.

Sec. 10-206.PA 04-221(1940-2004) Health assessments. Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse registered nurse, a physician assistant, or by the school medical advisor. The assessment includes: a physical examination; chronic disease assessment (i.e., asthma, lead levels), an updating of immunizations; and vision, hearing, speech and gross dental screenings. The assessment also includes tests for tuberculosis, sickle cell anemia or Cooley's anemia.

Sec 19a-2a PA 93-381(1993) Powers and duties. The Commissioner of DPH shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of DPH and the Public Health Code. He shall have responsibility for the overall operation and administration of DPH. All Title V Programs are impacted by this statute.

Sec. 19a-4j PA 98-250(1998) Office of Multicultural Health. The responsibility of the office is to improve the health of residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. All Title V Programs are impacted by this statute. Although the Office was eliminated through layoffs in 2003, activities continued and the Office was re-established in 2005.

Sec. 19a-4i PA 93-269(1993) Office of Injury Prevention. This office coordinates and expands prevention and control activities related to intentional and unintentional injuries, including surveillance, data analysis, integration of injury focus within DPH, collaboration, support and develop community based programs and develop sources of funding. This statute impacts many Title V Programs since injury is the leading cause of death for the 1 to 19 year old age population.

Sec. 19a-7 PA 75-562(1975) Public Health Planning. DPH shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities. All Title V Programs are impacted by this statute.

Sec. 19a-7a PA 90-134(1990) State goal to assure the availability of appropriate health care to all state residents. The goal of the state is to assure the availability of appropriate health care to all residents, regardless of their ability to pay. All Title V programs are impacted by this statute.

Sec. 19a-7c PA 90-134(1990) Subsidized non-group health insurance product for pregnant women. DPH with DSS may contract to provide a subsidized non-group health insurance for pregnant women who are not eligible for Medicaid and have incomes under 200% of the federal poverty level. Healthy Start, Comadrona, Family Planning, Community Health Centers (CHCs) are the programs most affected by this statute.

Sec. 19a-7f PA 91-327(1991) Childhood immunization schedule. An immunization program shall be established by DPH, cost of vaccine will not be a barrier to age-appropriate vaccination. CHCs and School Based Health Centers (SBHCs) are the programs most affected by this statute.

Sec. 19a-7h PA 94-90(1994) Childhood immunization registry. The registry shall include information to accurately identify a child and to assess current immunization status. CHCs and SBHCs are the programs most affected by this statute.

Sec. 19a-7i PA 97-1(1997) Extension of coverage under the Maternal and Child Health Block Grant. DPH shall extend coverage under Title V of the SSA to cover underinsured children with family incomes between 200% -300% of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the SSA. CYSHCN programs are most affected by this statute.

Sec. 19a-17b, PA76-413(1976) Peer Review: Definitions, immunity; discovery permissible from proceedings. There shall be no monetary liability against any person who provides testimony, information, records, etc. The proceedings of a medical review committee are not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising from matters subject to evaluation and review by such committee. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected by this statute.

Sec. 19a-25 PA 61-358(1961) Confidentiality of records procured by DPH or directors of health of towns, cities or boroughs. Describes the restricted use and confidentiality of all information, records of interviews, written reports, statements, notes, memoranda or other data procured by DPH or its representatives for the purpose of reducing the morbidity or mortality from any cause shall be used solely for the purposed of medical or scientific research and for disease prevention and control. All programs are influenced by this statute. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected.

Sec. 19a-32(1949) Department authorized to receive gifts. DPH is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government or by any person, corporation or association, provided such assets shall be used only for the purposes designated. All Title V Programs are impacted by this statute.

Sec. 19a-35 PA 35-240(1935) Federal funds for health services to children. DPH is designated as the state agency to receive and administer federal funds which may become available for health services to children. Title V Programs serving children are most affected by this statute.

Sec.19a-48(1949) Care for Children with Cerebral Palsy. DPH shall furnish services for children who have cerebral palsy including locating the children, providing medical, surgical, corrective and allied services and care, and providing facilities for hospitalization and aftercare. CYSHCN

programs are most affected by this statute.

Sec.19a-49(1961) Services for Persons with Cystic Fibrosis. DPH shall establish and administer a program of services for children and adults suffering from cystic fibrosis. CYSHCN programs are most affected by this statute.

Sec. 19a-38. PA 156(1965). Fluoridation of public water supplies. Wherever the fluoride content of public water supplies serving 20,000 or more persons supplies less than 8/10ths of a milligram per liter of fluoride, whoever has jurisdiction over the supply shall add a measured amount of fluoride so as to maintain the fluoride content. The Oral Health program is affected by this statute. /2008/The Oral Health Program has been renamed the Office of Oral Public Health.//2008//

Sec. 19a-50 PA 39-142 PA 37-430(1937, 1939) Children crippled or with cardiac defects. DPH is designated to administer a program of services for children who are crippled or suffering from cardiac defect and to administer federal funds which may become available for such services. CYSHCN programs are most affected by this statute.

Sec.19a-51 PA 63-572(1963) Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by DPH and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents, who are or may be patients of cardiac centers in this state. CYSHCN programs are most affected by this statute.

Sec. 19a-52(1981) Purchase of equipment for handicapped children. DPH may, purchase wheelchairs and placement equipment directly. CYSHCN programs are most affected by this statute.

Sec. 19a-53 PA 33-318(1933) Reports of physical defects of children. Each health care provider who has professional knowledge that any child under 5 years of age has any physical defect shall mail to DPH a report stating the name and address of the child, the nature of the physical defect and such other information. The CYSHCN Registry is supported by this statute.

Sec. 19a-54 PA 33-266(1933) Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to DPH, the name and address of each child under 21 years of age who is physically handicapped for whom application is made for admission, whether such child is admitted or rejected. The CYSHCN Registry is supported by this statute.

Sec. 19a-55 PA 65-108(1965, 2002) Newborn infant health screening. Each institution caring for infants shall cause to have administered to every infant in its care an HIV-related test, and a series of tests for disorders as listed in the attachment to this section. This bill has been amended to expand testing, as listed in the supporting document attached.

Sec. 19a-56a PA 89-340(1989) Birth defects surveillance program. The program shall monitor the frequency, distribution and type of birth defects occurring in CT on an annual basis. DPH shall establish a system for the collection of information concerning birth defects and other adverse reproductive outcomes. The CYSHCN Registry is supported by this statute.

Sec. 19a-56b PA 89-340(1989) Confidentiality of birth defects information. All information collected and analyzed pursuant to section 19a-56a shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the program. The CYSHCN Registry is supported by this statute.

Sec 19a-59 PA 81-205(1981) Program to Screen Newborn Infants for Hearing Impairment at Birth. Each institution that provides childbirth service will include a universal newborn hearing screening program as part of its standard of care and establish a mechanism for compliance review. DPH will establish a plan to implement and operate a program of early identification of

infant hearing impairment. Newborn Hearing Screening Program is supported by this statute.
/2007/This program is now called the Early Hearing Detection and Intervention Program.//2007//

Sec. 19a-59a PA 82-355(1982) Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. DPH may purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly. CYSHCN programs are supported by this statute.

Sec. 19a-59b PA 83-17(1983) Maternal and Child Health Protection Program (MCHPP). DPH shall establish a maternal and child health protection program to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children less than 6 years of age. Comadrona, Right from the Start, and Healthy Start are supported by this statute.

Sec. 19a-59c PA 88-172(1988) Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. DPH is authorized to administer the WIC program in the state, in accordance with federal law and regulations. WIC is supported by this statute.

Sec. 19a-60 PA 45-462(1945) Dental services for children. DPH may furnish dental services for children free of charge where the cost of necessary service would be a financial hardship to their parents. CHCs and SBHCs are affected by this statute.

Sec. 19a-90 PA 41-255(1941) Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state shall take a blood sample within 30 days from the date of the first examination and during the final trimester, and shall submit such sample for a standard serological test for syphilis. Family Planning, CHCs and SBHCs are affected by this statute.

Sec. 19a-110 PA 71-22(1971) Report of lead poisoning. Defines reporting requirements to DPH regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead. CHCs and SBHCs are affected by this statute.

Sec.19a-62a(2000) Pilot program for early identification and treatment of pediatric asthma. DPH, with DSS, shall establish pilot program for the early identification and treatment of pediatric asthma. The DPH Asthma Program is impacted by this statute.

/2008/Sec. 47-48 of Public Act 06-188 (2006) Medical home pilot program. The Commissioner of Public Health, in consultation with Medicaid managed care organizations, may establish a medical home pilot program in one region of the state in order to enhance health outcomes for children, including children with special health care needs, and evaluate such pilot program to ascertain specific improved health outcomes and cost efficiencies achieved not later than one year following the establishment of such program. The Children and Youth with Special Health Care Needs program is impacted by this Act.

Sec. 51 of Public Act 06-195 The Commissioner of Public Health shall establish an ad hoc committee for the purpose of assisting the commissioner in examining and evaluating statutory and regulatory changes to improve health care through access to school based health centers, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program.//2008//

CYSHCN Program Capacity in CT

The CYSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for

special needs, community-based service system and transition to all aspects of adult life. The CYSHCN/Regional Medical Home Support Centers (RMHSCs) are responsible for providing services to children receiving Supplemental Security Income benefits who meet program eligibility criteria. The 5 centers are The Stamford Health System serving Southwest CT, Yale School of Medicine, serving South Central CT, St Mary's Hospital serving Northwest CT, LEARN serving Eastern CT and Charter Oak Health Center serving North central CT. /2008/Contracts for LEARN and Charter Oak Health Center were terminated in 10/06 due to non-compliance with contract terms. The program is transitioning from a center-based approach to a more community based practice center approach to medical home. Based on the feedback from a Medical Home retreat DPH has issued an RFP for Care Coordination services.//2008//

The RMHSCs will enhance the capacity for medical homes in the region to screen children and assist the medical homes through community-based health care systems. There are an estimated total of 120,000 CYSHCN in CT. The second purpose of the RMHSCs is to improve availability of programmatic and health care service data on CYSHCN for evaluation and development of quality programs. Data and practice management for this new approach will be supported through Doc Site, a quality assurance web-based program. Multi-state agency Memoranda of Understanding (MOUs) will be utilized to support care coordination and data sharing on CYSHCN. /2008/DocSite is no longer being used for collecting information on clients receiving services through the medical home program. DPH Epidemiology staff developed a Microsoft Access database to assure that information on the clients receiving services continued. DPH staff who assumed the coordination of client services from the two de-funded regional medical centers were trained on the use of the Access database. The DPH epidemiology staff also shared the database with the other regional medical home centers, provided training and continued technical support for these centers.//2008//

/2009/CT has an estimated 133,000 CYSHCN.//2009//

Care Coordination, the core of both the RMHSCs and the medical homes will be technically supported to assure that there is an inter-agency collaboration in meeting the needs of the CYSHCNs. RMHSCs will also support families with community-based resources, family networking and building parent partnerships in medical homes. Funds for durable medical equipment, prescriptive medications, special nutritional formulas and respite care needs for the uninsured and underinsured families are available on a limited basis./2008/ Three RFPs have been issued to better operationalize the medical home project in CT; one for care coordination, one for administering the respite/extended services funds and one to provide provider and consumer outreach and education regarding medical homes.//2008//

Regional Family Networks (RFN) will be groups of parents and/or caregivers of CYSHCN whose primary responsibilities within this system include family support services & quality assurance for the service delivery system. RFN will serve as an additional support to the care coordinators within the RMHSCs on family-centered training and capacity building. /2008/ RFN will continue with the new contracts, family support will be funded through one contract and not through five to ensure a more cohesive group that will provide uniform supports and services. The proposed sub-contractor for this part of the contract will be the Family Support Network. Activities will include the following; DPH will continue to enhance the family-centered Medical Home concept in CT by the selection of a contractor to provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs, and, link these children to medical homes when available and family support services.//2008//

A CT Medical Home Learning Collaborative resulted from participation in the National Institute of Child Health Quality's (NICHQ) Medical Home Learning Collaborative with the purpose of improving care for CYSHCN by implementing the AAP's Medical Home concept. The collaborative meets quarterly and is open to all providers interested in building their capacity as a medical home, especially in meeting the needs of CYSHCN. A Medical Town News is published quarterly by DPH and posted on DPH's website. /2008/ The statewide systems strategic planning

work on medical homes for CYSHCN, initiated by the CT MHLC, is now being implemented and evaluated regionally by the RMHSC. The collaborative continues to meet quarterly.

The United Way's INFOLINE (211) Child Development Infoline (CDI) is the primary intake source for CYSHCN. CDI caseworkers assess the caller's situation, and make referrals to CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CYSHCN/RMHSC. The 211 component of Infoline, funded as CT's Maternal and Child Health Information and Referral Service, will work closely with the RMHSCs on their resource information updates./2007/DPH initiated a Medical Home Advisory Council, which is comprised of representatives from state agencies, community-based organizations and parents of CYSHCN. Their mission is to provide guidance to DPH in its efforts to improve the community-based system of care for CYSHCN./2007//

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: Initially funded through the SSDI Initiative and in-kind support, staff are working to develop internal mechanisms and evaluate the DPH's capacity to collect population based breastfeeding data. As a result of these efforts, in January 2004 the Electronic Newborn Screening Database started to collect data from all birthing hospitals on the mother's intent to breastfeed. /2007/DPH has identified a state Breastfeeding Coordinator who is co-funded by the MCHBG and USDA/WIC funding./2007//

Comadrona: DPH contracts with the Hispanic Health Council of Hartford to provide culturally appropriate intensive case management services to pregnant Latina and African-American women and their children who reside in the greater Hartford area. /2008/ An RFP will be issued for this program in 2006-7//2008//
/2009/ RFP was issued./2009//

Family Planning: Through its contract with Planned Parenthood of CT, Inc., comprehensive reproductive health services are available in 15 locations across the state. Family Planning promotes decreasing the birth rate to teens age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. /2007/There are now 16 sites./2007//
/2008/There are currently 12 DPH-funded Planned Parenthood program locations & 4 Delegate Agency locations./2008//

Fetal and Infant Mortality Review (FIMR): Six high-risk communities are funded to examine confidential, de-identified cases of infant deaths, with a goal of understanding how local social, economic, public health, educational, environmental and safety issues relate to infant deaths in order to improve community resources and service delivery. To complement and expand the FIMR process, Perinatal Periods of Risk will be introduced next year. /2007/DPH will develop a statewide surveillance system to identify health related FIM issues to gain understanding of how and why communities take action to prevent fetal and infant deaths, and identify additional geographic areas of need./2007//
/2008/An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant mortality to understand what motivates and mobilizes communities to take action to prevent fetal and infant deaths. The statewide effort will identify areas of greatest need and involve community collaboration, case ascertainment utilizing vital statistics and other data sources and record review./2008//

Healthy Choices for Women and Children (HCWC): HCWC provides intensive case management services to low income, pregnant and postpartum women who abuse substances or are at risk for abusing, or whose partner abuses substances, and their children from birth to age 3, who reside in the city of Waterbury or surrounding communities. Referrals and linkages to community-based health and health related services are provided.

Healthy Start: This statewide collaboration between DSS and DPH aims to reduce infant

mortality, morbidity and low birthweight, and to improve healthcare coverage and access for children and eligible pregnant women. Last year, DPH signed a collaborative agreement with the federal New Haven Healthy Start Program. Several priorities emerged as common concerns: Male Involvement; MCOs; Care Coordination; Consortium Development; FIMR/PPOR; and Data Collection. /2008/ DPH continues to collaborate with the Federal New Haven Healthy Start and has renewed its letter of agreement.//2008//

Maternal and Child Health Information and Referral Service (MCH I&R): DPH contracts with the United Way of CT to administer the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. More information on INFOLINE is noted above. /2007/In 2005, DPH received a grant award from HRSA to develop a statewide public awareness campaign regarding perinatal depression. The statewide Perinatal Depression Workgroup successfully recruited consumers and professionals of diverse backgrounds to participate.//2007//
/2008/United Way of CT has reconvened its MCH Advisory Committee. This committee has been inactive for about 10 years; the DPH Perinatal Advisory Committee will be integrated with the MCH Advisory Committee.//2008//

Oral Health: The Office of Dental Public Health has a comprehensive public health strategy for the prevention of oral diseases and disorders in CT's children and their families. The Office works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period, and has partnered with DSS to implement a Dental Loan Repayment Program for dentists and hygienists to work in underserved areas of the state. Work is currently underway to develop a new state oral health plan. /2008/The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

Pregnancy Related Mortality Surveillance (PRMS): An OB-GYN consultant conducts maternal mortality reviews and based on findings, provides education to medical providers to prevent future maternal deaths. /2007/A report is near completion for PRMS for the decade 1991-2000.//2007//
/2008/The program will continue to conduct maternal mortality reviews and meet with providers to prevent future deaths.//2008//
/2009/Completed 10-yr. report (see attachment).//2009//

Right from the Start (RFTS): Located in four communities, the RFTS program provides intensive case management services to pregnant and/or parenting teens. Services provided by community-based contractors must include: intensive case management; outreach and case-finding activities; promotion of breastfeeding; integration of the USPHS/Smoke Free Families Smoking Cessation Intervention model; and public awareness activities. Services must be comprehensive, culturally appropriate, community-based and family centered. /2008/An RFP will be issued in 2006-7 to provide case management services to pregnant women and teens to promote healthy birth outcomes in up to 3 communities in the state. This program will address interconceptional care counseling, male involvement, health disparities, breastfeeding, smoking cessation, and develop community capacity and collaboration with key stakeholders.//2008//

Sudden Infant Death Syndrome (SIDS): In previous years, DPH provided bereavement services to families statewide who experienced a sudden infant death, based on referrals from the Office of the Chief Medical Examiner. Services included home visits, referrals to community-based services, and follow-up. A statewide assessment of cultural appropriateness of bereavement services is currently being conducted. Upon completion, MCHBG funding will be allocated to expand access to and awareness of bereavement services for fetal and infant mortality, including SIDS events. /2007/In 2005, there were 11 SIDS events in the state. As a result of the statewide bereavement assessment, DPH is developing an Infant Mortality public awareness campaign targeted to the African American community. This campaign will be in collaboration with the Federal New Haven Healthy Start Program.//2007//
/2008/ An Infant Mortality Campaign to increase awareness around infant mortality in the African

American population and to promote early prenatal care will kickoff in June 2007.//2008//

SSDI: CT is focusing on 3 main activities: assess and enhance programmatic data collection systems in order to improve DPH's ability to report on the many required outcome measures; expand the linkage of the Birth and Supplemental Nutrition Program for Women, Infants and Children (WIC) to include a linkage with the state Medicaid eligibility files; and develop and evaluate a database for community-based providers who participate in the CYSHCN Medical Home Learning Collaborative. /2008/The 2007-2011 SSDI Project goals have been modified to (1) Further enhance the FHS programmatic data collection systems to improve and increase the availability of quality data for the MCHBG and MCH programs, and (2) Develop data dissemination systems of analytic reports and presentations to help inform public health programs at the state and local level.//2008//

The Injury Prevention Program (IPP): In collaboration with its many partners, the program provides resource materials, and technical assistance on injury prevention issues for Title V funded programs and other community service providers. The Program also facilitates the Interagency Suicide Prevention Network. /2007 IPP was transitioned from FHS to the Health Education, Management and Surveillance Section (HEMS). FHS maintains a strong collaboration with this program.//2007//

/2008/FHS continues to provide ad hoc support to the IPP for the developing Injury Surveillance System and its related grant requirements. This includes obtaining in-patient hospitalization and Emergency Department data from the CT Hospital Association.//2008//

Title V Partnership Programs for Children and Adolescents, Age 1 through 22 years.

Comadrona: As described above.

Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 63 SBHCs in 19 communities, serving students in grades pre-K-12. Licensed as outpatient facilities or hospital satellites. They offer services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention.

/2007/DPH now funds 65 SBHCs in 19 communities.//2007//

/2008/DPH now funds 68 SBHCs in 20 communities with three additional communities providing expanded school health services.//2008//

/2009/DPH now funds 73 SBHCs in 20 communities.//2009//

Expanded School Health Services (ESHS): DPH funds 2 ESHS projects. One site focuses on preventing and improving mental health status and service referral for children and youth in a regional school system and one site provides access of physical and behavioral health services to preschool aged children and families who are at risk for learning in one community.

/2008/DPH now funds an additional ESHS program that provides mental health and dental services to students in eight elementary schools in a high need community. This brings the total number of funded ESHS programs to three. //2008//

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach efforts at health fairs, teen life conferences, and statewide events to provide reproductive health and STD prevention literature, as well as conducting community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH I&R): As described above.

Oral Health: DPH funds 6 School Based Programs to improve dental access and services underserved children as well as conduct ongoing surveillance for planning purposes of dental health status of youth through the CT BRFSS.
2007/DPH now funds 4 School Based programs.//2007//

Right from the Start: As described above.

The Early Childhood Partners (ECP): The ECP Comprehensive Systems Plan aims to create an integrated service system that incorporates comprehensive health services, early care and education, family support and parent education to ensure the sound health and full development of children. The CT Early Childhood Cabinet was established by the State Legislature in 2005 and created CT's early childhood framework: Ready by 5 & Fine by 9. The Cabinet includes the Commissioners of the departments with primary responsibility over early childhood services.
/2007/Please see the program update in the Overview section.//2007//

The Injury Prevention Program (IPP): The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. The Program, in collaboration with partners to facilitates the Interagency Suicide Prevention Network and participates in the Youth Suicide Advisory Board. /2007/As described above, IPP was transitioned to the HEMS section.//2007//

Title V Partnership Programs for Children with Special Health Care Needs

Children & Youth With Special Health Care Needs (CYSHCN): Children who are screened for special health care needs and are either uninsured or underinsured may be eligible for durable medical equipment, prescriptive pharmacy and special nutritional formulas. The CYSHCN program also offers a limited respite program based on available funds, and transition services to adult care. /2008/An RFP was developed and issued for administering the Respite and Extended Services Funds. The CT Lifespan Respite Coalition was selected as the contractor for this service.//2008//

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serve as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients. See the attachment to this section for the list of CT Newborn Screening Panel Disorders.

Oral Health: The Office of Dental Public Health addresses the oral health needs of CYSHCN through health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CYSHCN program.

Pregnancy Exposure Information Services (PEIS): PEIS provides information and referral services via a statewide toll-free telephone number to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, and occupational exposure. /2008/ A total of 988 calls were received by the PEIS hotline, with 967 risk assessments performed and treatment plans developed which included counseling services.//2008//

School Based Health Centers: SBHCs provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. In such cases, they coordinate the care they provide with a child's primary and specialist caregivers, and provide support while the child is in school. /2007/SBHCs help CYSHCN students transition from a school setting to the community upon graduation by linking them to needed services.//2007//

Sickle Cell Program: The 2 State funded Regional Sickle Cell Programs, located at Yale University and CCMC, provide comprehensive care programs that include confirmation testing, counseling, education and treatment for newborns identified with hemoglobinopathies through the NBS program. The Sickle Cell Disease Association of America located in New Haven and Hartford serves youth with transition to adult health providers and provides educational programs to increase community awareness. The Southern Regional Sickle Cell Association enhances testing, counseling, case management in the Southwest region of CT.

/2007/The Hospital of Special Care, in New Britain, is planning to implement sickle cell education/training to health professionals in CT who provide care to those with sickle cell disease.//2007//

/2008/A three-day sickle cell certification training was conducted and 30 people participated (14 were certified as hemoglobinopathy counselors, 5 attained the level of professional educator, 8 became peer educators and 3 did not complete the course). DPH provided stipends to families/consumers who attended and completed the training.//2008//

Universal Newborn Screening: The statewide Universal Newborn Screening (UNBS) program is a population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing, counseling, education, and treatment services. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 30 birthing facilities in the state implemented a UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospital staff notify the primary care providers of all infants who are in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to 3 Program. /2007/The Early Hearing Detection and Intervention (EHDI) program works with 16 diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth.//2007//

Cultural Competency

The Office of Multicultural Health was re-established in April 2005. Cultural Competence language is standard for Title V funded contracts as of July 1, 2003. The FHS staff remain committed to addressing cultural competency during site visits to contractors. Staff have developed an assessment tool to assure that our contractors are providing culturally appropriate services containing key items to be discussed during a site visit. A check box on DPH's Site Visit Monitoring Tool reminds staff to discuss and address cultural competency during site visits.

DPH is presently working with a consultant to assess and evaluate breastfeeding initiation and duration rates of African American/ Black women in CT. Consultant will make recommendations to DPH on ways to improve these rates. DPH collaborated with the CT Breastfeeding Coalition (CBC) to develop and produce a document in English and Spanish describing CT's breastfeeding laws. This document is mailed to all new mothers in CT.

/2007/Recommendations from the CT Breastfeeding Assessment finalized in 2005 included the use of peer education models, particularly at sites serving the women least likely to breastfeed; engaging Black churches and other Black institutions by recruiting and training church leaders to

the benefits of breastfeeding; exploring sources of reimbursement for breastfeeding classes; and publicizing existing free breastfeeding support and information.//2007//
/2008/Recommendations from the CT Breastfeeding Assessment included training of health care professionals.//2008//

DPH continues to address the health care needs of CT's homeless population by implementing activities outlined in the Healthcare for the Homeless Strategic Plan. DPH has provided funding to 10 CHCs to enhance and strengthen the infrastructures and linkages with homeless shelters while enabling the center's ability to effectively address the healthcare needs of CT's homeless population. The CT Youth Health Service Corp., a program co-funded by DPH and prepares high school youth for careers in the health care field, includes a module in its curriculum regarding working with the homeless population and a module on cultural competency.

/2008/DPH is contracting with the Latino Community Services Inc, to support the LCS' faith based initiative. LCS has developed a relationship with 33 faith based organizations in CT and has developed a Learning Academy which include modules on cultural and linguistic competence, coalition building on addressing health disparity

An attachment is included in this section.

C. Organizational Structure

Governor M. Jodi Rell has been serving as CT's Governor since July 2004. Dr. J. Robert Galvin, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of Connecticut.

DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. DPH is a source of health information used to monitor the health status of CT's residents, set health priorities and evaluate the effectiveness of health initiatives. The agency is a regulator of the health community, focusing on health outcomes while maintaining a balance between health status and administrative burden. DPH works to prevent disease and promote wellness through community-based education and programs.

As a result of agency-wide focus groups and strategic planning workshops conducted in late 2004, DPH was reorganized and is now comprised of eight Branches. The Oral Health Program, previously located in the Family Health Section, is now the Office of Oral Public Health and is under the auspices of the Deputy Commissioner. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

Within the Public Health Initiatives Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Section Chief of the Family Health Section (FHS) and as the Title V Director. The majority of CT's Title V program activities reside organizationally within the FHS of the PHI Branch, however, other MCH related programs such as oral health, nutrition, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are located organizationally in other Sections within the Public Health Initiatives Branch. Other Branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. For example, in the Laboratory Branch staff analyzes blood specimens from newborns for genetic screening. In the Planning Branch, Health Information Systems and Reporting Section, under the direction of Julianne Konopka, vital record data bases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health are maintained. Epidemiologists within this branch use vital record information to help direct and evaluate Title V program activity.

/2007/The Childhood Lead Poisoning Prevention program is no longer in the PHI Branch.

The program is now centralized in the Regulatory Services Branch.//2007//

/2008/Childhood lead poisoning prevention activities are centralized in the Lead Poisoning Prevention and Control Program of the Regulatory Services Branch.//2008//

/2008/Janet Brancifort, Public Health Services Manager has joined the PHI Branch and has been assigned to the FHS. The Primary Care and Prevention Unit and School and Adolescent Health Unit Supervisors report to Ms. Brancifort.//2008//

/2008/Laboratory Branch staff analyze (1) blood specimens from newborns for genetic screening, (2) blood specimens from children for lead and (3) environmental samples related to lead.//2008//
/2009/The Office of Multicultural Health has been relocated to the Planning Branch. The comprehensive Cancer program is now part of the HEMS Section. Charlene Gross, Administrative Assistant has joined the FHS as the AA for Lisa Davis. Ms. Gross was previously in the Office of Multicultural Health.//2009//

The Family Health Section has identified their mission as "improving the health of CT's resident across the lifespan through culturally appropriate surveillance, public education, family-centered interventions and community-based capacity building." FHS's core purpose is "to optimize the health of families" with a vision that "all individuals and families achieve optimal health through appropriate and comprehensive health services." FHS will develop crucial business alliance and work with both internal and external stakeholders as partners to optimize the health of families. The Family Health Section is comprised of three units: Women, Men, Aging & Community Health (WMACH); Child, Adolescent & School Health; and Epidemiology and Injury Prevention. Programs within each unit are defined in the Other (MCH) Capacity section of this report. This structure enables the FHS to focus on and improve the health status of individual members of a family as a cohesive unit. The WMACH unit primarily focuses on the adult members of a family and their public health primary care access point, however, safety net providers such as the CHCs, provide services to clients throughout the entire lifespan. The Child, Adolescent & School Health unit focuses on the pediatric and adolescent members of a family and their public health primary care access point. The Epidemiology and Injury Prevention unit is structured to focus on supporting the programs with necessary data analyses and program evaluation to track and measure results and ultimately assure that identified objectives are attained and provide quality care/services to Title V clients.

/2007/The FHS is now comprised of five units. The Child, Adolescent and School Health Unit has been divided into three units: the School and Adolescent Health Unit, the Newborn Screening Unit and the CYSHCN Unit. With the transition of the Injury Prevention Program to another section, the Epidemiology and Injury Prevention unit is now known as the Epidemiology Unit. The ECP project is managed by staff who report directly to the Title V Director.//2007//

/2008/The Women, Men, Aging and Community Health Unit has been renamed the Primary Care and Prevention Unit. This name change more accurately reflects the scope of services provided by this Unit. Other Units in the FHS include: Epidemiology Unit, School and Adolescent Health, Children and Youth with Special Health Care Needs and Newborn Screening. The ECP program is seeking a Health Program Assistant 1 who will function as the ECP Program Coordinator.//2008//

/2009/Christine Buckley has been hired as the HPA-1 for the ECP Program.//2009//

The Office of Dental Public Health is organizationally located outside of the PHI Branch and reports directly to the Deputy Commissioner. Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Although organizationally in a different area within DPH, a strong collaborative relationship exists with the MCH programs.

/2007/New to the Office of Dental Public Health is Linda Ferraro, RDH. FHS Epidemiology Unit continues to support this Office's programs.//2007//

/2008/The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

/2009/The renamed Office of Oral Health has recruited a part-time clerical support staff and a full-time Health Program Associate.//2009//

Sharon Tarala, RN, JD is the Supervising Nurse Consultant of the WMACH unit. Staff within this unit work on the following programs: CT Youth Health Service Corp, Comadrona, CHCs, Family Planning, FIMR Program, Healthy Choices for Women and Children, Infant Mortality Bereavement Services, Intimate Partner Violence, MCH Referral and Information Services,

Pregnancy Related Mortality Surveillance, Primary Care Office, Right from the Start, and Sexual Assault Prevention and Intervention.

/2008/The Women, Men, Aging and Community Health Unit has been renamed the Primary Care and Prevention Unit.//2008//

/2009/The CT Youth Health Services Corp, Bereavement Services, Comadrona and the Right from the Start Program are no longer provided by the DPH. An RFP was issued to integrate the Comadrona and Right from the Start Program activities into a new case management program for women who are ineligible for the State Healthy Start and Nurturing Families Programs. This program was developed to help ensure that pregnant women were not falling through the cracks and not receiving duplicate services. Three community-based programs for the new case management services are located in Waterbury, Hartford and New Haven.//2009//

Dorothy Pacyna, MS, RN is the Supervising Nurse Consultant of the Child, Adolescent & School Health Unit. The programs served by these staff are: Abstinence Only Education, Expanded School Health Services, SBHCs, Children and Youth with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Universal Newborn Hearing Screening, Universal Newborn Screening, Early Childhood Partners Program and Family Advocacy.

/2007/The CYSHCN program is supervised by Dorothy Pacyna, RN. This unit has been responsible for the implementation of the five Regional Medical Home Support Centers. The FHS Family Advocate who works closely with staff to provide support for all areas of the Medical Home System reports to Ms. Pacyna.//2007//

/2007/The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, MPH consists of the Newborn Genetic Screening program (Maternal PKU, Sickle Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sickle Cell Disease Transition program.//2007//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes the Abstinence Only Education program, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/Dorothy Pacyna retired from State service and has been replaced by Mark Keenan, RN, Supervising Nurse Consultant, CYSHCN Program, which now includes Medical Homes and the EHDI Program.//2008//

/2008/ The EHDI program is now part of the Children and Youth with Special Health Care Needs Program. Plans are underway to re-located the metabolic screening program to the State Laboratory.//2008//

/2008/The Abstinence Only Education Program is no longer funded in CT.//2008//

/2009/The CYSHCN Program was awarded a HRSA State Implementation Grant for Integrated Community Systems for CSHCN. A new staff position will be established to conduct grant activities. The EHDI program was just awarded a CDC data integration grant.

The Coordinated School Health Grant was awarded to the State Department of Education and an MOA will be developed to establish a position at the DPH to assist with the grant activities.

The School and Adolescent Unit was awarded a State Agency Partnership for Promoting Child and Adolescent Mental Health grant from HRSA. //2009//

Marcia Cavacas, MS, Epidemiologist 4, is the supervisor for the Epidemiology and Injury Prevention Unit. Programs in this unit include the Child Health Access Project, Crash Outcome Data Evaluation System (CODES), Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and the Injury Prevention Program.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known

as the Epidemiology Unit. The Epidemiology Unit seeks to identify, collect, and analyze population-based MCH data and create new systems that complement existing data and that will enhance capacity for programmatic planning, evaluation and surveillance.//2007//
/2008/The Crash Outcome Data Set (CODES) project was moved to the HEMS Section where the Injury Prevention Program resides. The Epidemiology Unit in the FHS continues to provide ad hoc support to both the CODES Project and IPP's Injury Surveillance System. The Epidemiology Unit in the FHS is also responsible for the Birth Defects Registry.//2008//
/2009/The Epidemiology Unit has filled the Epidemiologist 2 position that supported the Birth Defects Registry.//2009//

Coordination of the development of the Title V Block Grant is supervised by Julianne Konopka, Section Chief of the Health Information Systems and Reporting (HISR) Section in the Planning Branch. It is a collaborative effort between the FHS and the HISR Section on all aspects of the Block Grant Application and Annual Report development. Also under the supervision of Julianne Konopka is the State Office of Vital Records. Epidemiologists within this Section use vital records information to help direct and evaluate Title V program activity and also provide epidemiological support to the FHS and Title V programs.

/2007/The coordination of the development of the MCHBG application will be transitioned to staff in the FHS.//2007//

/2008/FHS staff has taken over the responsibility for coordinating the MCHBG application process.//2008//

Resumes are included as Supporting Documents and are on file at DPH for Lisa Davis, Marcia Cavacas, Dorothy Pacyna, and Sharon Tarala. DPH Organizational charts are attached to this section and included in the Supporting Documents Section.

/2007/ Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes are included for Mark Keenan and Janet Brancifort//2008//

An attachment is included in this section.

D. Other MCH Capacity

The CT Department of Public Health is comprised of eight Branches, a new organizational structure as a result of agency-wide focus groups and strategic planning workshops in late 2004 and implemented February 2005. Within the Public Health Initiatives (PHI) Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Director of the Family Health Section (FHS) and as the Title V Director. Robin Lewis provides secretarial support to Ms. Davis. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch.

/2007/ Ms. Davis was promoted to Section Chief, Family Health Section effective December 2005.//2007//

/2008/ Jackie Douglas now provides secretarial support to Ms. Davis. In addition to functioning as the Title V Director, and Chief for the FHS, Ms. Davis was recently selected to participate in the Robert Wood Johnson Executive Nurse Fellows Program. Participation in this program will help strengthen Ms. Davis' leadership skills. In addition, Ms. Davis is participating in the AMCHP Title V Directors mentor program and is being mentored by Sally Fogerty of the MA DPH.//2008//

/2009/ Charlene Gross has been assigned the Administrative Assistant to Lisa Davis, Title V Director. ECP Program staff and the Unit Supervisors report to Ms. Davis. In addition, Janet Brancifort, Public Health Services Manager, provides managerial support to Ms. Davis and the FHS.//2009//

Sharon Tarala, RN, JD was recently promoted to Supervising Nurse Consultant and is now responsible for the Women, Men, Aging and Community Health Unit. Staff within this unit include Nurse Consultants Donna Fox, RN, MA, and Anthony Mascia, MSN, RN. Additional staff include

Health Program Associates Marilyn Binns, Felicia Epps and Veronica Korn. These staff work on the following programs: Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review, Healthy Choices for Women and Children, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, Sexual Assault Prevention and Intervention.

/2007/Anthony Mascia, Donna Fox, Marilyn Binns, and Veronica Korn no longer work in this unit. Additional staff include Shiu-Yu Kettering, Health Program Associate and Lauren Backman, Epidemiologist 3. Staff in this unit now work on the Healthy Start program and the MCH Referral and Information Services program is now within the and School and Adolescent Health Unit.//2007//

/2008/ this Unit has been renamed to the Primary Care and Prevention Unit. Ms. Tarala is the State Women's Health Coordinator. The Primary Care Office grant and activities are housed in this Unit.//2008//

/2009/ Staff within the Primary Care and Prevention Unit include Kimberly Pelletier and Hope Mitchell, both Health Program Assistants 1, and Nurse Consultants Donna Maselli and Regina Owusu. Comadrona and Right from the Start funding was blended and based on MCH data, a new Case Management for Pregnant Women Program was created. Perinatal Depression activities, including the Perinatal Consultative Line, and the Waterbury Health Access Program are also housed in this unit. In addition to Fetal Infant Mortality Review, a statewide Fetal Infant Mortality Surveillance program, contracted through the University of CT is now in place.//2009//

Within the Child, Adolescent and School Health Unit, The CYSHCN program is supervised by Dorothy Pacyna, RN and includes Epidemiologist Chun-Fu Liu, and Health Program Associates Robin Tousey-Ayers and Ann Gionet. Ms. Gionet also serves as a Family Advocate, and works closely with staff to provide support for all areas of the Medical Home System with focus on the respite component, the Regional Family Support Network (RFSN). She also provides consultation to staff regarding family issues, participates in the development and review of appropriate program policies to ensure that a family-centered, culturally competent perspective is maintained. The Newborn Screening program in this unit, led by Vine Samuels, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Shiu-Yu Kettering and Health Program Assistant Amy Okrongly. The School and Adolescent Health Program in this unit, led by Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Health Program Associate Linda Durante Burns and Nutrition Consultant Charles Slaughter. Rose Marie Mitchell provides secretarial support to the unit. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, Children and Youth with Special Health Care Needs, Genetic Services, Maternal PKU, Pregnancy Exposure Information Services, Sickle Cell Services, Sickle Cell Transition, Universal Newborn Screening (metabolic and hearing). Kevin Sullivan, Health Program Associate, is responsible for coordinating the CT Early Childhood Comprehensive Systems (Early Childhood Partners, ECP) program.

/2009/ Christine Buckley has joined the ECP program as an HPA1.//2009//

/2007/ The new CYSHCN Unit, led by Dorothy Pacyna, Supervising Nurse Consultant, includes Health Program Associates Ann Gionet, who is part time, and Robin Tousey- Ayers. There is one Health Program Associate position vacant. This unit has been responsible for the implementation of the 5 Regional Medical Home Support Centers. Ms Gionet, the FHS Family Advocate, provides coordination activities related to the Family Support Network protocols and advocacy for families. Ms Tousey-Ayers coordinates activities for the Medical Home Network protocol as well as coordinating with the A.J. Pappanikou Center, which was responsible for facilitating this year's regional inter-agency workgroups on youth transition. The Health Program Associate position formerly held by Ms Burns would coordinate the utilization of the Extended Service and Respite Funds and DocSite training activities.//2007//

/2008/ The CYSHCN Unit is now under the supervision of Mark Keenan, Supervising Nurse

Consultant (Ms. Pacyna retired from state service). In addition to Ms. Tousey-Ayers and Ms. Gionet, the Consumer Information Representative position will be filled by mid-summer. The Newborn Hearing Screening Program is now housed in the CYSHCN Unit.//2008//

/2009/ Michael Fuller has been hired as a Consumer Information Representative for the CYSHCN Unit. In this role, which nicely complements the part-time Family Advocate (Ann Gionet), Mr. Fuller is responsible for providing technical assistance and responding to technical consumer inquiries.//2009//

/2007/ The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, BA, MPH, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Marilyn Binns and Health Program Assistant 1 Amy Mirizzi. This program consists of Newborn Genetic Screening (Maternal PKU, Sickle Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sickle Cell Disease Transition program. Gloria Powell, RN, Nurse Consultant will begin in the NBS program in July.//2007//

/2008/ The metabolic newborn screening program remains under the supervision of Vine Samuels. The Newborn Hearing Screening program has been relocated to the CYSHCN Unit. It is anticipated that by mid-summer the metabolic screening program staff will be relocated to the state laboratory.//2008//

/2009/Newborn metabolic screening staff are now housed at the State Laboratory. This provides NBS staff with timely access to screening results. The vacant Health Program Assistant position with this program has just been filled. Amy Mirizzi of the EDHI Program has been promoted to Health Program Associate and Kathryn Britos-Swain, Nurse Consultant has been assigned to the CYSHCN Unit.//2009//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Social Worker Meryl Tom, LCSW and Cheryl Poulter, Health Program Assistant Trainee. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/ Donna Heins, Nurse Consultant in the SAHU also functions as the State Adolescent Health Coordinator.//2008//

/2009/Reginal Owusu is now in the Primary Care and Prevention Unit and Faraz Wasti has joined the SAHU as a Health Program Assistant.//2009//

Marcia Cavacas has been promoted to Epidemiologist 4 and serves as the supervisor of the Epidemiology and Injury Prevention Unit. Clerical support is provided by Jacqueline Douglas. Epidemiologists Carol Stone, PhD., and Jennifer Morin, MPH support programs across FHS. Social Worker Meryl Tom and Health Program Associates Marian Storch and Margie Hudson also serve programs in the unit including Child Health Access Project, Statewide Systems Development Initiative (SSDI), Children with Special Health Care Needs Registry, CODES and injury prevention activities. This unit is currently recruiting for two Title V-funded Epidemiologist 2 positions.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known as the Epidemiology Unit. New to this unit in the past year are Chunfu Liu, MS, MPH, Johanna Davis, and Ann Kloter, MPH, who now support programs across FHS. Meryl Tom, Marian Storch and Margie Hudson have relocated along with their programs to other units. The Unit seeks to identify, collect and analyze population-based MCH data, and to create new systems that complement exiting data that will enhance FHS's capacity for programmatic planning, evaluation and surveillance.//2007//

/2008/ The CODES project has been relocated to the Health Education Management and Surveillance (HEMS) Section where the injury prevention program is located.//2008//

/2009/We will closely monitor the staffing for the Epidemiology Unit. As we increase the utilization of, and gain access to MCH data, additional staff may be necessary. We will also

continue to identify other datasets that impact the MCH population.//2009//

Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Recruitment continues for staffing to support the activities conducted by this Office.

/2007/ Linda Ferraro, RDA has now joined the Office of Dental Public Health as a Health Program Associate.//2007//

/2008/ Staff are collaborating with the Office of Dental Public Health, which has been renamed the Office of Oral Public Health, to submit a HRSA grant application for Perinatal oral health.//2008//

/2009/ Two new staff have joined the Office of Oral Public Health; Title V funding helps to support the activities of this Office that impact the MCH population.//2009//

Within the Planning Branch, the Health Information Systems and Reporting Section, support through the preparation of the MCHBG application is provided. Also, Epidemiologists Diane Aye, MPH, PhD, Marijane Mitchell, MS, Celeste Jorge, BA, and Associate Research Analyst Federico Amadeo, MPA provide epidemiologic support to FHS programs and through their work on other programs such as the Connecticut School Health Survey, Health Professional Shortage Areas, and Vital Statistics.

/2008/ FHS has assumed the role of preparing the MCHBG application.//2008//

Within the Administrative Branch, support to Title V programs is given by the Contracts Management Division and Fiscal Services. At the State Public Health Laboratory, Lab Assistant Leslie Mills offers support to the Newborn Screening program. Resumes are on file at DPH for Lisa Davis, Dorothy Pacyna, Marcia Cavacas, and Sharon Tarala and can be found in the Supporting Documents section.

/2007/ Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes for Mark Keenan and Janet Brancifort are included.//2008//

An attachment is included in this section.

E. State Agency Coordination

CT's Title V Program has established working relationships with the organizations found in the document attached to this section. Because of the diverse programs funded by the Block Grant, DPH works with other state agencies and within its own programs to insure coordination of services. Please see the attachment to this section for a listing of all organizations. The narrative below describes the most important of those collaborations.

Abstinence-Only Education program staff work closely with School Based Health Centers (SBHCs), the CT Association of Schools, and other State and local agencies and organizations affected by the project, including CYSHCN Program, STD Program, AIDS Program, SDE, DSS, DCF, and OPM. Staff coordinate with representatives of Network CT, a SPRANS community-based abstinence education grantee, to share information and resources, including but not limited to peer mentors and counselors, parent/guardian outreach activities, and public awareness activities, such as radio spots, program brochures and posters.

/2008/The Abstinence program is working closely with UConn to evaluate its Abstinence Education Program.//2008//

/2009/The Abstinence-Only Education program evaluation was completed last year and DPH doesn't conduct any related activities.//2009//

The CYSHCN program collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential enrollees to the Program. CYSHCN program staff also network with the Bureau of Rehabilitation Services at DSS regarding the provision of occupational services to youth transitioning to adulthood.

Staff from DPH and the CYSHCN Regional Centers participate on: DCF Advisory Committee for Medically Fragile Children in Foster Care, DMR's Birth to 3 Public Awareness and Medical Advisory Committee and Interagency Coordinating Council (ICC), and the legislatively mandated Family Support Council. /2007/Staff participate on the DPH Medical Home Advisory Council which provides guidance and advice to DPH in its efforts to improve the system of care for CYSHCN. DPH partnered with the A.J. Pappanikou Center on Developmental Disabilities to coordinate the roles of state agencies in meeting the challenges of care coordination. The Center also facilitated meetings with community-based organizations on best practices to meet the needs of CYSHCN.//2007//

/2008/DPH staff participate in the AJ Pappanikou Center's Consumer Advisory Council.//2008//
/2009/DPH staff participate on the DSS ABCD Screening Academy, Pay for Performance, and Primary Care workgroups.//2009//

Memoranda of Understanding are being drafted by DPH with multiple state agencies (DSS, DMR, DCF, SDE). Through these agreements, the parties intend to recognize their shared goals and to establish methods of coordination and cooperation to ensure that CYSHCN and their families/caregivers who are served by the Regional Medical Home Support Centers (RMHSC) receive timely and comprehensive health care services.

/2008/The MOU were put on hold due to the new direction of the medical home project.//2008//
/2009/DPH has included DSS, DDS (formerly DMR) and DCF on the Medical Home Advisory Council.//2009//

DPH joined in partnership with United Way of CT/2-1-1 Infoline, DMR (Birth to 3), and the Children's Trust Fund (Help Me Grow) supporting the CDI to serve as the centralized point of entry for all CYSHCN in a system of care. CDI will develop and implement a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to 3, Ages and Stages, Help Me Grow and a local RMHSC. /2007/DPH contracted with CREC/Soundbridge to implement the Listen & Learn program which provides follow-up of infants identified through the EHDI program who were not eligible for Birth-to-3 services.//2007//

DPH, through its partnership with the CHDI, contracted with AHEC to develop and implement a Medical Home Academy (MHA) for pediatric physicians, nurses, other allied health professionals, and families. The CT MHA was introduced as one full-day Medical Home Implementation Conference on March 8, 2005.

DPH and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create a two-section "Get Creative About Respite" manual. To determine the importance of respite services and provide information to families in the state, DPH conducted a needs assessment and found the top 5 gaps included planned respite, emergency respite, after school programs, summer day camp, and summer overnight camp. DPH contracted with CT Lifespan Respite Coalition, Inc. to provide 8 statewide information sessions on the Get Creative About Respite manual. /2008/ "Directions: Resources for Your Child's Care" an information organizer for families, was made available.//2008//

DPH is working with the Champions for Progress Center housed at the Early Intervention Research Institute at Utah State University for assistance in the production of leadership to accelerate the process of systems building at the state and community levels. The Champions for Progress Center assists with the development of private/public partnerships using a Participatory Action Research Approach (PARA), coordinates State/territory plans and activities with partners around the 6 core measures for CYSHCN.

The Newborn Screening program staff work with the 30 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Screening Hearing and Laboratory Programs.

A Newborn Screening program staff is an active member of the CT Newborn Hearing Screening Task Force. The Task Force members include representatives from the DSS, DMR, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other agencies, that promotes optimal outcomes for infants identified with hearing loss.//2007//The EHDl program contracted with the UConn Division of Human Genetics to develop a web based training for pediatric healthcare providers on genetic testing in newborns and partnered with the UConn Communication Disorders Center and the American Speech and Hearing Association to offer continuing education units to audiologists who attend annual training.//2007//
/2008/ The web-based training was launched in April.//2008//
/2009/To date, 207 providers have accessed the web-based training.//2009//

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc.

A DPH CT Genetics Stakeholder Advisory Committee was formed to advise the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers and genetic counselors; and consumer advocates. /2007//The committee is now known as the CT Expert Genomics Advisory Panel. FHS staff participate on these panels. One serves as co-chair on the Services Workgroup, and another participates on the Sciences Workgroup.//2007//

/2007//In January 2006, a Statewide Sickle Cell Planning group was developed to address transition services for youth and adults with Sickle Cell. The planning group is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, university students and DPH staff. DPH was approved for MCHB TA for a consultant to develop the comprehensive statewide sickle cell plan.//2007//

/2008/ MCHB TA was utilized to develop a statewide sickle cell plan.//2008//

/2009/Staff participate in the Sickle Cell Consortium and the statewide plan is on the DPH website and has been widely disseminated to 9 other states and the National Sickle Cell Disease Association.//2009//

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participate in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

Site Coordinators of SBHCs meet bi-monthly with FHS staff to address grantee issues, training and technical assistance, information and resource sharing and input on overall project direction. CT SBHCs have formed a non-profit independent organization, the CT Association of SBHCs, Inc., to advocate for this service delivery model.

Sixty-three SBHCs in 18 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHCs are licensed as outpatient facilities and staffed by both Advanced Nurse Practitioners and Licensed Social Workers. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. Students

enrolled in the SBHCs are provided with early periodic screening, diagnosis and treatment (EPSDT). The practitioners coordinate the care they provide with a child's primary and specialist caregivers, while integrating the needs of the child with other school personnel. /2007/There are now 65 SBHCs in 19 communities.//2007//

/2008/ A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHCs, particularly by under- or uninsured people or Medicaid recipients.//2008//

/2009/Ad Hoc Committee continues to meet and presents annual report to legislature.//2009//

Child, Adolescent and School Health Unit staff are engaged in the interagency steering team of the Coordinated School Health Program. This team is comprised of members from DPH, SDE, and DCF. A Nurse Consultant with DPH's SBHC program is an active member of the State Adolescent Health Coordinator's Network, which is a national association of all state and territorial adolescent health coordinators, and a member of the National Assembly on School Based Health Care. Staff also participate in the Regional Stakeholders Group, with representation from DPH and SDE. The group works to enhance collaboration on issues of HIV, STDs, and Abstinence.

Within the Women, Men, Aging and Community Health Unit of the FHS, MCH program staff represent DPH on the New Haven Family Alliance, Male Involvement Network, The Community Foundation for Greater New Haven Perinatal Partnership Committee, and DSS's Fatherhood Initiative Council.

/2008/ FHS staff will participate on the Advisory Committee for DSS' Responsible Fatherhood Grant.//2008//

In an effort to build and strengthen community collaborations and to provide technical assistance to our community partners, DPH, in collaboration with the United Way of CT/Infoline 211, developed "A Resource Manual Designed to Help CT Communities Develop and Sustain Coalitions." It will complement the MCH Training, "Developing and Sustaining Coalitions" that was conducted in 2004 by The Consultation Center in New Haven.

Community Health Centers (CHCs) provide comprehensive primary and preventive health care and other essential public health services at 39 sites, and many additional sites for health care for the homeless. All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. Approximately 176,894 people were served with 782,000 visits documented in 2004. Patients served within the CHCs are provided with a wide variety of comprehensive services, including EPSDT. The CHCs also work with Family Planning, WIC, SBHCs, Infoline and many community based organizations that provide other health care and social services.//2007//In 2005-6, Torrington Community Health Center was awarded state funding which is administered through the DPH.//2007//

/2008//In 2005, over 200,000 people sought services, generating nearly 900,000 visits to CHCs.//2008//

/2009//In 2006, CHCs continued to serve over 200,000 clients. Comprehensive information is on DPH website.//2009//

The statewide family planning program is implemented through a contract with Planned Parenthood of CT in 15 sites (10 Planned Parenthood centers and 5 designated agencies). The services provided include comprehensive preventive and primary reproductive health care for adolescents and adult males and females. During FY 2004, 41,838 clients received services. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy (including abstinence education), STIs, Hepatitis and HIV/AIDS. /2007//A new Planned Parenthood site was added in Danbury.//2007//

/2008// Planned Parenthood of CT has 16 sites and during FY 06, 33,669 clients received services.//2008//

/2009/Planned Parenthood of CT has 16 sites and during FY 07, 32,092 clients received services.//2009//

All DPH-funded community health centers in CT are members of the CT Primary Care Association (CPCA). DPH and CPCA work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHCs. Among these are the CT River Valley Farmworker Health Program (in conjunction with the Massachusetts League of CHCs), National Health Service Corps recruitment and retention activities, immunization program initiatives, breast and cervical cancer screening, domestic violence prevention and homelessness.

***/2008/ DPH contracted with two CHCs to pilot a perinatal depression screening tool.//2008//
/2009/DPH contracted with Yale University to provide perinatal depression (PD) screening trainings to OB physicians and established a PD consultative line. CPCA changed its name to Community Health Center Association of CT. DPH collaborated with them to provide materials to share with CHCs. In order to promote interest in careers in health care, Be A Health Care Hero brochures were mailed to guidance counselors at several hundred middle and high schools statewide.//2009//***

In collaboration with CPCA, a Healthcare for the Homeless Advisory Board was established and a conference was held to strengthen links between healthcare providers and shelters. A needs assessment of homeless persons in CT and a strategic plan to improve the health status of CT's homeless men, women and children was conducted. The Advisory Board is in the process of implementing activities identified in the strategic plan. Mini-grants were provided to 10 CHCs to better address and link homeless persons in their communities with primary health care services.

DPH partnered with AHEC to co-fund and implement the CT Youth Health Service Corp (CYHSC) with a purpose of promoting teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and support workforce development by facilitating the transition of youth from school to employment in the health care field, particularly with underserved populations. A curriculum was developed that provided students with information on confidentiality/HIPPA, Homelessness 101, Ethical and Legal Issues and Applied Health Services. */2008/Although this program continues to operate, DPH no longer funds the CYHSC through the PCO grant.//2008//*

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHCs, HMOs, Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. In May 2005, in collaboration with the DPH, the CBC sponsored a symposium attended by over 100 health care providers, which focused on the integration of breastfeeding support in office practices. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state.

/2008/The goals of the CBC have been revised to a mission to improve CT's health by working collaboratively to protect, promote and support breastfeeding.//2008//

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region 1 Workgroup to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region. The DPH convened a collaborative workgroup, "Going Home Healthy," at York Correctional Institute, the State's only female correctional facility, with the purpose of transitioning women back into the community healthy. The workgroup is comprised of representatives from various state and community-based agencies and has developed a community-specific resource guide and gender-specific discharge cards soon to-be released inmates. In addition, DPH funded contractors have been invited to participate in the on-site "community days" so that

inmates have a better understanding of where and how to access health and social services in their particular community of discharge.

/2008/DPH will execute an MOA with the DOC & UConn to facilitate activities & training regarding Intimate Partner Violence for inmates and staff at the YCI. DPH has formed a partnership with the Hartford Community Court and the DSS to work with adolescent fathers.//2008//

/2009/DPH executed an MOA with DOC and a contract with CT Women's Consortium to provide gender based training regarding Intimate Partner Violence for inmates and staff at YCI.//2009//

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (ConnSacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.

/2008/During National Women's Health Week, DPH provided health screenings (blood pressure, BMI, etc.) to state employees.//2008//

/2009/DPH collaborated with CT VNA Partners, American Lung Association and American Cancer Society during National Women's Health Week in May.//2009//

Facilitated by Central AHEC, DPH convened the statewide perinatal advisory committee. The purpose of this committee was to develop a comprehensive, statewide plan to address perinatal health services in CT. Representation on the committee included: the State Agencies DPH, DSS, DCF, DMHAS, and also the New Haven Health Department, New Haven Healthy Start, The CT Hospital Association, CT Women's Consortium, CT Chapter of the March of Dimes, Real Dads Forever, Planned Parenthood of CT, CPCA, Permanent Status on the Commission of Women, AAP, UConn Department of Neonatal and Perinatal Medicine, UConn Department of Obstetrics and Gynecology, and the CT State Medical Society. The Advisory Committee identified 9 goals and objectives to address the perinatal health needs in CT.

/2007/The Perinatal Depression Workgroup is comprised of representatives from the DPH, DMHAS, DSS, Local Health Departments, CT Chapters of the AAP, ACOG, Nurse Midwives, and March of Dimes, United Way of CT/ Infoline, Yale University, UConn, CT Women's Consortium, PCSW, CPCA, CHCs, Office of Rural Health, and consumers. A statewide summit was convened in May 2006 and the perinatal depression campaign (print and media) will be launched in the summer. //2007//

/2008/The Perinatal Advisory Committee will be integrated with the recently reconvened Infoline MCH Advisory Committee. The Perinatal Depression Workgroup remains active.//2008//

/2009/The MCH Advisory Committee met quarterly to discuss topics of interest and make recommendations for implementation of the Perinatal State Health Plan.//2009//

CT's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the FHS and the CT Chapter of the March of Dimes. The mission of the Coalition is to promote the health and well being of women and children in CT through leadership, collaboration, and resource sharing.

Within the Surveillance, Evaluation, and Quality Assurance Unit (SEQA) of FHS, staff has worked to establish the CT Birth Defects Registry and work closely with birthing units within the hospitals of the state. A web-based reporting system for the CYSHCN is used by medical homes and Regional Medical Home Support Centers (RMHSC), and is linked to the registry at DPH. Infoline is working with DPH and has become the single entry-point of CYSHCN for referrals to the Birth to 3 Program and the RMHSC for needed services.

SEQA staff represent DPH on the steering committee for Early Childhood Data CONNEctions, a public-private partnership of DSS and CHDI to bring together stakeholders to address the needs for better information on key early childhood indicators. The goal is to further build the capacity of state government to collect, analyze and report key information on the needs and services for

young children (birth to age 8) and to develop and facilitate a research agenda for advancing early childhood public policy through partnerships.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data.

/2008/The first addendum of the Data Sharing MOU related to the linkage of birth & Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid.//2008//

SEQA staff act as the state identified data contact for the Office of Women's Health Region 1 database project. Staff has facilitated the collection of the health status information needed for this database and coordinated the subsequent in-state training for use of this database.

/2008/FH Epidemiology staff continue to coordinate the provision of data to the OWH Region 1 database.//2008//

DPH has worked with the Office of the Governor through the Governor's Collaboration for Young Children to establish The Healthy Child Care CT initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the 5-member Leadership Team that guides the Healthy Child Care CT, along with the executive director of the Children's Health Council. The team has established a regional Core Committee representing organizations that play a key role in the planning and delivery of childcare and health care for children and their families. Healthy Child Care CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the Healthy Child Care CT initiative, DPH collaborated with staff from DSS, Yale University School of Nursing, UConn Stamford, and Southern CT State University to conduct a 6-day training program for Day Care Health Consultants, Education Consultants and Directors of Day Care Facilities. This program addressed many aspects relating to the health and safety of children in day care facilities.

The CT Coalition to Stop Underage Drinking, designed to curb under age drinking, involves all state agencies and advocacy groups across the state. The coalition is headed by the Governor's Partnership Project, Drugs Don't Work! and is funded by the RWJ Foundation.

CT does not function on a county-based system for the delivery of public health services to its residents. However, the Commissioner of DPH, through the Local Health Administration Branch, assists and advises local health districts in the state as they play a critical role in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.

The Early Childhood Partners Initiative established a steering team and developed a memorandum of agreement with the Commission on Children to co-sponsor a roundtable on shared outcomes. The ECP process brought together 8 State agencies and statewide institutions, and the community to create a performance-based, outcome-driven Strategic Plan to support all CT families so their children arrive at school healthy and ready to learn. /2007/The ECP Steering Committee was expanded and convened. The DPH's Deputy Commissioner has been appointed to the new Governor's Early Childhood Education Cabinet. The purpose of the Cabinet is to develop a strategic plan to assure that children enter kindergarten fully ready for school success //2007//

/2008/Plans are underway to better integrate the goals of the ECP plan into that of the ECE Cabinet.//2008//

/2009/DPH applied for the SAMHSA Project LAUNCH grant and is also partnering with DSS & DCF to better integrate social-emotional health into the EC system.//2009//

To address intentional and unintentional injuries, DPH staff collaborate with the CT DOT, SDE, DCF, DSS, OCA, CSSD, and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. DPH facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive suicide plan. DPH also works with collaborators to address violence prevention, domestic violence and child maltreatment. DPH staff participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, University Injury Research Centers and representatives from Federal Regional Offices. The Network collaborates on injury prevention initiatives of relevance to both the region and the individual states.

/2008/ An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant.//2008//

/2009/The legislature sustained funding for the FIMR Programs to continue. The new MOA between DPH and UCONN allowed new efforts to begin to look at fetal and infant mortality surveillance statewide.//2009//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	40.2	31.5	32.0	39.5	
Numerator	658	658	676	802	
Denominator	163615	208772	211036	202831	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2007

CY 2007 hospitalization data not available.

Notes - 2006

Source: CY 2006 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch.

Notes - 2005

Source: CY2005 OHCA data provided by CTDPH, Planning Branch, 2005 population estimates provided by Backus & Mueller, OHCQSAR.

Narrative:

/2009/ The rate of children less than five years of age hospitalized for asthma has increased in CY 2006. One should note that while the numerator did increase, this was accompanied by a decrease in the denominator. It would be premature to assume that this increase is one that will continue.

According to a recent report "Asthma in Connecticut 2008: A Surveillance Report" (Peng, J, Rodriguez, R, Hewes, S (2008) Asthma in Connecticut 2008: A Surveillance Report, Connecticut Department of Public Health, Health Education, Management and Surveillance Section, Hartford, CT. Funding provided by the Centers for Disease Control and Prevention, Grant Number 2U59EH124179-04), the trends in hospitalization and ED rates for children less than 5 years were comparable to those reported here. The trends were similar in showing the highest rates in 2002 and 2003 followed by a decrease in 2004. While data reported here show a slight increase in 2005 of 0.5, the surveillance report showed only a slight decrease of 0.6 in 2005. This appears to indicate both sources agree that not much change occurred from 2004 to 2005. DPH Asthma Program staff are aware of this unwanted trend in the asthma rate and staff are collaborating with other New England states using BRFSS data to attempt to learn more. The Asthma Program focus is on identification, treatment and control of asthma among the CT population including children. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	84.6	85.3	87.9	86.2	86.6
Numerator	13108	13475	14386	14429	15133
Denominator	15497	15795	16369	16739	17475
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Source: CT Dept of Social Services, 2007 CMS 416.

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, Form CMS 416, FY2005.

Narrative:

/2009/ The percent of Medicaid children less than one year who received at least one periodic screen increased slightly from CY 2006 (86.2%) to 86.6% in CY2007. While this CY2007 figure is not higher than the CY2005 it returns to the increasing trend from CY2003 and CY 2004. It should be noted however that the actual number of children < 1 year receiving at least one periodic screen has increased each year from 2003 to 2007. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	74.6	79.4	81.0	73.7	82.0
Numerator	403	377	482	365	445
Denominator	540	475	595	495	543
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Source: CT Dept of Social Services, SFY2007 HUSKY participation report.

Notes - 2006

Source: CT Dept of Social Services, SFY2006 HUSKY participation report.

Notes - 2005

CT Dept of Social Services, HUSKY B Annual Reports submitted by MCO's, SFY2005.

Narrative:

//2009/ The percent reported for SCHIP enrollees < 1 year who received at least one periodic screen shows a general increasing trend with the exception of the CY2006 data point. Also the figures reported by DSS for CY2007 are of a magnitude that is out of line with previous years. It is for this reason that we have indicated that these data are provisional and will be pursuing this issue with DSS. Unlike the Medicaid enrollees, the actual number of SCHIP children < 1 year receiving at least one periodic screen is erratic. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	84.3	80.7	80.2	80.2	
Numerator	34977	32962	32773	32809	
Denominator	41467	40841	40885	40898	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2007

CY 2007 Vital Statistics data not available.

Notes - 2006

Source: CT Dept of Public Health, Final 2006, Vital Statistics.

Notes - 2005

Source: CT Dept of Public Health, Final 2005, Vital Statistics.

Narrative:

/2009/ In CY2006, 80.2% of women (15 through 44 years) with a live birth during the reporting year whose observed to expected prenatal visits were greater than or equal to 80% on the Kotelchuck Index. This was the same percent as reported in CY 2005. This measure has been showing a decreasing trend over the years. Further analysis would be required to determine whether there were significant variations within this cohort of women based on age, race, health insurance or other factors. Appropriate programmatic interventions could then be tailored to the problems identified. This information would be helpful in informing activities that could be incorporated into several Title V programs: Healthy Start, HCWC, Case Management for Pregnant Women, CHCs and WIC. National Performance Measure #18 reports that in CY2006, 85.8% of women in CT began prenatal care in the first trimester and SPM#6 reports that in CY 2006, 69.8% of infants born to women < 20 years received prenatal care in the first trimester - both of these measures not meeting the expected goal. All of these measures point to a need to further investigate the issues surrounding prenatal care access.//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	44.2	46.9	47.9	48.8	52.2
Numerator	111992	121521	129346	137566	145359
Denominator	253576	258978	269941	281910	278677
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Source: CT Department of Social Services, 2007 CMS 416

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, CMS 416, CY05

Narrative:

/2009/ The percent of potentially Medicaid-eligible children who received a service paid by the Medicaid program has steadily increased over the years. In CY2007, 52.2 % of Medicaid-eligible children received a service paid by Medicaid that is an increase from CY 2006 of 49.8%. The actual number of children receiving a service also shows a steady

increase over the years. In the past 2 years, funding has been allocated for HUSKY outreach. A number of Title V and non-Title V programs direct their infrastructure building activities to children and adolescents to improve access and utilization to health care.
//2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	45.4	46.5	43.7	48.1	53.0
Numerator	24073	25099	24689	26848	29007
Denominator	52981	53922	56549	55848	54775
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Source: CT Dept of Social Services, 2007 CMS 416.

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, Form CMS 416, 2005

Narrative:

//2009/ The percent of EPSDT-eligible children aged 6 through 9 who have received any dental services during the year shows a general increasing trend with the exception of the CY2005 data point. Similarly, the actual number of children has shown a steady increase with the exception of CY2005. The actual numbers of children receiving dental services jumped from a low of 16, 309 in 2000 to 29,007 in 2007, a 78% increase in children age 6 through 9 who have received any EPSDT dental services during the year.//2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	7.3	3.6	3.6	39.9	
Numerator	396	76	47	2397	
Denominator	5419	2120	1296	6008	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
-----------------------------------	--	--	--	-------	--

Notes - 2007

CY 2007 data not available.

Notes - 2006

Source: In CY 2006, the CYSHCN Program estimated that approximately 85% (2397) of children served by the CYSHCN Program are under 16 years of age. The denominator is the number of children in CT under 16 years receiving SSI reported on the Healthy and Ready to Work website (www.hrtw.org).

Notes - 2005

Source: CT Dept of Public Health, CYSHCN Program, estimate based on one quarter's data ending 12/05. (Federal and state database are currently in transition.)

Narrative:

/2009/ In CY 2006, the numerator is the estimated number of CYSHCN under 16 years that received rehabilitative services from the CYSHCN Program. The denominator is the number of children under 16 in CT receiving SSI reported on the Healthy and Ready to Work website (www.hrtw.org). //2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	matching data files	9.5	7.4	8

Notes - 2009

Source: DPH Vital Statistics final 2005 matched births to Medicaid eligibility information. CY2006 data are not available.

Narrative:

/2009/ CY birth cohort files are matched to Medicaid eligibility information by a sub-contractor under agreement with DSS. DPH has a Memorandum of Agreement with DSS to ensure that this record matching is completed every year. The most recent data available was the CY 2005 cohort.

For all four indicators in this measure, the Medicaid population shows poorer outcomes than the non-Medicaid population.

The column labeled "all" contains Vital Statistics information for 2005 for the entire state population.//2009//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				MEDICAID	
Infant deaths per 1,000 live births	2005	matching data files	9.4	4.3	5.7

Notes - 2009

Source: DPH Vital Statistics final 2005 matched births and infant mortality to Medicaid eligibility information. CY2006 data are not available.

Narrative:

/2009/ See narrative under HSCI #05A //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	matching data files	76.9	90.3	86.7

Notes - 2009

Source: DPH Vital Statistics final 2005 matched births to Medicaid eligibility information. CY2006 data are not available.

Narrative:

/2009/ See narrative under HSCI #05A //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to	2005	matching data files	73.6	82.5	80.2

80% [Kotelchuck Index])					
-------------------------	--	--	--	--	--

Notes - 2009

Source: DPH Vital Statistics final 2005 matched births to Medicaid eligiblty information. CY2006 data are not available.

Narrative:

/2009/ See narrative under HSCI #05A //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	300

Narrative:

/2009/ Infants (0-1), Medicaid children age 1-16years, and Pregnant Women are eligible for Medicaid if the family income is less then 185 percent of the poverty level. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 16) (Age range to) (Age range to)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	300

Narrative:

/2009/ See narrative under HSCI #06A //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's	YEAR	PERCENT OF POVERTY LEVEL
---	-------------	---------------------------------

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		Medicaid
Pregnant Women	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	250

Notes - 2009

Source: HSCI#06 CT Department of Social Services. Percent of poverty level for eligibility in State's Medicaid and SCHIP programs increased for Pregnant Women as of 1/1/2008.

Narrative:

/2009/ See narrative under HSCI #06A //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2009

Narrative:

/2009/ There has not been any change to this measure since last year's application. Work continues as part of SSDI goals and objectives to obtain regular access to WIC eligibility files that will allow linkage to the birth records. CT is planning to conduct a third PRATS survey (the survey similar to CDC's PRAMS) with some added questions around perinatal depression and discrimination related to health care access. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2009

Narrative:

/2009/ The percent of adolescents in grades 9-12 who reported using tobacco in the past month was 16.9% according to the 2007 CT School Health Survey. This is lower than the 2007 national figure of 20.0% and a very slight decline from 17.0% in 2005. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The priority needs presented in the next section were identified through a comprehensive needs assessment during August 2004 through May 2005, to identify state MCH priorities, to arrange programmatic and policy activity around these priorities, and to develop state performance measures to monitor the success of their efforts. The MCH needs assessment was designed to be population-based, community-focused, and framed within a family context.

The MCH Director established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs, staff from the Health Information Systems and Reporting Section, and staff from the Health Education, Management, and Surveillance Section.

In order to include key stakeholders in a meaningful and integral part of the needs assessment, DPH staff identified and convened an initial collaborative meeting with many invited state agencies and community and professional organizations. The MCH Director presented an overview of the MCH Block Grant and the required five-year needs assessment at the initial collaborative meeting. This collaborative group, which met several times over a six-month period, also provided oversight of the community centered needs assessment.

The Planning Committee also determined that the needs assessment process would include two components: 1) DPH Internal Needs Assessment, and 2) Community Centered Needs Assessment. The DPH Internal Needs Assessment process gathered data and reports housed at DPH, interpreted the data for programmatic implications, and recommended 7-10 state priority needs. The Community Centered Needs Assessment process identified community level data and reports, and all methods of collecting community data. This provided a forum for community input into the determination of the state priority needs.

Each Internal Needs Assessment workgroup was instructed to recommend 5 priority needs for a total of 15 priority needs to be considered by the DPH Planning Committee. It was part of the Planning Committee's charge to reduce the recommended 15 priority needs to 7-10 state priority needs. The Planning Committee, after much discussion and consideration, drafted a set of state priority needs, which were subsequently considered along with those identified by the Community Centered Needs Assessment.

In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. A health profile was developed for target populations including women, pregnant women, children, adolescents and children with special health care needs (CYSHCN). Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Planning Committee met in late May 2005, to review the identified priority needs from the Internal and Community Centered Needs assessment components to assure that the three population groups were appropriately included and establish measurable State Performance Measures. The MCH program selected seven priority needs from the list of potential areas for improving maternal and child health. Criteria used to select top priorities include the likelihood that the intervention will result in improved maternal and child health outcomes, the feasibility of success, and alignment with federal MCH priorities. The DPH Planning Committee added an eighth priority need regarding health disparities as it was deemed a repeated imperative need across the MCH population. The DPH Planning Committee also added a ninth priority need as part of the collaborative work of the federal Region I states to "measure the collective assets of

their childhood health systems."

/2007/ This measure was further developed by Region 1 Title V directors to measure the percentage of licensed child care centers serving children age birth to five who have onsite health consultation.//2007//

/2008/ During the 2006-07 grant year, FHS staff had in-depth conversations with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."//2008//

The nine identified State Priority Needs are similar in many ways to those identified 5 years ago. The similarities include the need to address data capacity issues, reduce injuries to children and adolescents, improve child adolescent health status with an added focus on overweight/obesity, enhance CYSHCN services especially family support services, increase access to health care for women and children, and reduce the health disparities that continue to exist specifically in the areas of teen pregnancy, low birth weight, prenatal care, breastfeeding, and infant mortality. One change was the removal of the priority need related to asthma diagnosis and management, as DPH has enhanced its capacity to more effectively address this issue through the now well-established DPH Asthma Program. Another change was the inclusion of the need to address asset-based measurement efforts among the federal Region I states.

/2009/ There are no changes to the priority needs at this time. In the fall, we will begin to map out the process for conducting the next five-year MCH Needs Assessment that is due with the 2011 Application. We will review the former process utilized and identify any additional funding that will be required to complete the process. There will be a stronger emphasis placed on community/parent/consumer input.//2009//

B. State Priorities

Through the Needs Assessment process completed for the 2006 Application, DPH identified nine areas of priority needs. These nine areas and how they relate to the National and State Performance Measures, and the capacity and resource capability of the Title V program are described below.

1. Strengthen Data Collection and Reporting

Effective decision-making requires timely and useful data on maternal and child health. One strategy that DPH implemented was the creation of the Virtual Children's Health Bureau (VCHB) in the fall 2004, whose charge was to remove barriers to the effective and efficient sharing of data across sections of the agency to fully maximize the use of child health information. The resulting commitment from DPH staff and executive leadership was the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids).

The information from HIP-Kids will be an important data source to enhance the DPH's ability to report on performance measures, as well as other required outcome measures. It also will support the goal outlined in the Health Systems Capacity Indicator #9A "the ability of states to assure that the MCH Program and Title V agency have access to policy and program information and data."

This priority need is somewhat related to HP2010 23-11: (Developmental) Increase the proportion

of State and local public health agencies that meet national performance standards for essential public health services.

The SPM #1, to create HIP-Kids, will support interdivisional public health research activities and initiatives. A broadly accessible data system will enhance the capacity to conduct public health assurance and assessment activities within Connecticut, and will also inform public health policy. Some enhanced essential activities that are anticipated include reducing health disparities among childhood disease prevention activities through better outreach to "hard to reach" populations; increasing ability to evaluate population-based health activities within DPH; improving data quality through better data validation and coordinated data improvement efforts; and enhancing comprehensive data accessibility to support grant activities and health programming.

/2008/ The creation of HIP-Kids fit well with EPHT's goal to develop and modify systems that meet the Public Health Information Network (PHIN), National EPHT Network, & the Environmental Protection Agency's (EPA) Environmental Exchange Network requirements. The data warehouse will collect data from a variety of existing sources, with enhancements to the collection processes for some of that data, & make it available to the DPH to support their query, extraction, & reporting needs.//2008//

2. Establish Collaborative Relations at the State/Local Level

The MCH Program acknowledges that improving the health and well-being of women and children requires a collaborative response from state agencies and community providers. For this reason, the MCH Program proposes to enhance and establish formal processes to collaborate with state and local stakeholders committed to improving the health of women and children. Specific issues best addressed through collaborations with state and local partners include increasing access to needed services such as mental health, oral health, specialty care and health services in rural communities, and expanding access to health insurance for low income populations.

While there are no specific National Performance Measures (NPMs) that directly relate to this priority need, the NPMs seek to improve the health of women and children, and many NPMs can only be achieved by collaborating with other state agencies. Similarly, there are no HP2010 objectives that specifically discuss fostering and implementing collaborations with state and local stakeholders, however there are numerous HP2010 objectives relating to the overarching goal to improve the health of women and children (refer to Form 16).

/2008/ FHS Staff are working with the DOC to implement a gender responsive curriculum for both DOC staff and inmates at YCI. An MOA between DPH and UCONN was executed to develop a statewide fetal and infant mortality surveillance system.//2008//

3. Reduce Intentional Injuries

The increase in violence and intentional injuries poses a serious public health threat to the adolescent population. Participation in fights is one marker of violent behavior that often results in serious injuries. Efforts to decrease violent behavior will help reduce intentional injuries to adolescents.

The single NPM most closely related to this priority need is #16, the rate of suicide deaths among youths. The selection of this priority need and the related SPM to reduce the number of injuries to adolescents in grades 9-12 due to violence and intentional injury, was purposely identified as part of an early intervention and prevention concept with the intent to address the tendencies to violent and injurious behaviors at an earlier stage. There are three HP2010 objectives that were cited related to this priority need from the Injury and Violence Prevention Chapter of the HP2010 document (see Form 16).

There are several Title V programs (e.g., CHCs and SBHCs) that already address this priority need through education and prevention programs, as well as specific programs like anti-bullying

campaigns.

/2008/ FHS provides support to the IPP for the developing Injury Surveillance System & its related grant requirements, including obtaining in-patient hospitalization & ED data from the CT Hospital Association.//2008//

4. Improve Adolescent Health Status

Adolescents of diverse racial, ethnic backgrounds and those of low socio-economic status who live in very rural sections of the state are at especially high risk for mental health, substance abuse and unintentional injuries. They need easy access to age-appropriate services and are often under-served due to the gap between pediatric and adult medical care services. SBHCs are reaching a number of adolescents but are only available at some schools and not in others. In addition, there is a sub-population of adolescents who are not reached because they are not in school due to dropping out, being incarcerated or are migrant workers.

While there is no specific NPM to address the increase in access to age-appropriate services for adolescents 10-20 years, HP2010 1-4b addresses this priority need with the goal to increase the proportion of persons who have a specific source of ongoing care (Children and youth aged 17 years and under). The HP2010 objective states that, "Young children and elderly adults, aged 65 years and older, are most likely to have a usual source of care, and adults aged 18 to 64 years are least likely. Young adults aged 18 to 24 years are the least likely of any age group to have a usual source of care."

The availability of age-appropriate services for adolescents through the SBHCs has been a positive model in which there has been moderate increased capacity to serve adolescents. The new SPM #4 related to this priority need will seek to further increase this capacity.

/2008/ A legislatively mandated SBHC Ad Hoc Committee was formed with the goals of improving health care through access to school-based health centers (SBHCs).//2008//

5. Promote Nutrition and Exercise to Reduce Obesity

Obesity and its consequences is now the top emerging public health issue in the state. Its importance as a priority health issue stems from it being a preventable condition that is increasing across all major public health population groups, and that it is linked to health problems such as heart disease and Type II diabetes. Obesity is an ideal health issue for community wide action that addresses all aspects of its prevalence among the MCH population.

While there is no NPM that addresses obesity/overweight directly, the new Health System Capacity Indicator #9C seeks to measure whether States have the ability to determine the percent of children who are obese or overweight. CT should be able to obtain percentages from the 2007 and 2009 CT School Health Survey (with a YRBS component) to determine this percentage. As a complimentary approach, the SPM developed for this priority need was focused on the reduction of overweight/obesity in the child and adolescent population with the increase in the number of public schools using educational programs to reduce obesity through physical exercise and nutrition education. /2007/ As part of the new 2007 Guidance, there is now an NPM (# 14) which addresses obesity and overweight in young children.//2007//

There are several HP2010 objectives that were cited related to this priority need (see Form 16).

The capacity for the State to address this priority need will be possible through a formal collaboration with the Department of Education (see new SPM #2) to promote culturally appropriate physical activity and nutrition in schools. This would be especially possible through the Coordinated School Health Model. /2007/ DPH is pursuing the use of the School Health Program Report Card that will be administered by SDE which is based on CDC's School Health Policies and Programs Survey (SHPPS). The SDE is planning to implement the survey to obtain the data for the Report Card in April 2006 from all public schools, and annually thereafter.//2007//

/2008/ DPH was successful in obtaining the survey data from the SDE's School Health Program Report Card & will use these data to report on this SPM.//2008//

6. Increase Access to Pre-conception Education and Parenting

Overall Connecticut's families and children fare well compared to their national counterparts with respect to key national indicators of maternal and child health. Birth rates in Connecticut are lower than national rates; there are proportionally fewer pre-term births; and there are smaller percentages of low birth weight babies. Connecticut children overall are also more likely to receive primary care services, including dental care and other routine and preventive services.

However, there are great disparities in many of the key health indicators between certain segments of the state's population, particularly between teens and adult populations and White (non-Hispanic) majority and minority populations. The causes of some of these disparities are linked to poverty, racism, and other societal problems but many of the disparities are also clearly linked to lack of proper pre-conception education, parent education, and other parenting supports. Young and inexperienced parents, as well as parents with limited knowledge of healthy behaviors and habits, need to have better access to formal, quality pre-conception and parenting education programs.

This priority need directly relates to NPM 18, with a focus on the women under age 20 years, since it was identified that the teen population was a disparate group needing particular attention, as well as race and ethnic disparities. There were three HP2010 objectives identified from the Maternal, Infant and Child Health chapter (see Form 16).

CT could address this priority need by: identifying and promoting the development of quality pre-conception and parent education programs, particularly in the schools and in areas where there are high rates of teen births; developing and disseminating culturally appropriate educational materials and curricula geared to teens and young adults; tracking the number of teens and young adults who receive quality pre-conception and parent education in schools and in other community settings; and promoting provider training and education programs geared to encouraging brief pre-conception counseling and parenting education and referral to community-based educational programs.

/2008/ DPH is partnering with the HHD on their CDC/CityMatCH TA grant to address preconception care. An RFP will be issued for case management services for pregnant women (and teens) in July 2007. This new program is expected to include parenting classes.//2008//

7. Promote access to family support services including respite care and medical home system of care for Children and Youth with Special Health Care Needs

According to data collected by the SLAITS survey there could be as many as 118,000 children with special health care needs living in CT. A number of agencies in the State assist CYSHCN and their families by providing and facilitating family support services including respite care. The two major agencies are DPH and the Department of Mental Retardation (DMR). Great strides have been made to identify and serve families with CYSHCN in the state, particularly families with young children but there are still many families who struggle and efforts need to be made to: 1) improve access to family support and respite care, 2) increase the overall service capacity and the resources available for home and respite care, and 3) support families who have trouble identifying respite providers.

This priority need has three NPMs that relate to the need to increase access to family support services including respite care and the medical home system of care for CYSHCN (NPM #2, #3 and #5). This SPM was developed with the particular focus on assuring that families have access to respite services and the new medical home system of care. There were 3 HP2010 objectives identified related to this priority need (see Form 16) including that have a focus on medical home and service systems for CSHCN.

To address this priority need, the State will use the newly initiated community-based system of care for children and youth with special health care needs. This initiative complements the American Academy of Pediatrics belief that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

Five RMHSCs will be contracted as of July of 2005. Through linkages, the outcome is for the RMHSC to increase the number of children screened and identified with special health care needs in the region by coordinating family support services and respite care, educating health and social service providers on the resources available to families of CYSHCN, collaborating with community-based organizations, colleges and universities in the state, particularly those with training programs for students who want to provide services to CYSHCN; and promoting the development of respite care practicum programs that link students to families who need respite care services.

/2008/ The medical home program is transitioning from a center based approach to a community based approach.//2008//

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and Geographic location. (Specific issues: teen pregnancy, low birthweight, prenatal care, breastfeeding, and infant mortality)

Compared to national statistics, CT residents report good health status overall, however, large health disparities exist between the White population and that of the African American/Black and Hispanic populations within CT. This issue was identified in the last needs assessment conducted four years ago, and remains one that DPH needs to focus efforts. Specifically, lack of access to health care for low income and uninsured populations differs across these populations. Even women with health insurance lack access to mental health, oral health and specialty care services including follow-up procedures and testing due, in part, to high out-of-pocket expenses.

Lack of access to basic needs negatively impacts overall health status of target populations. There are documented delays in seeking care by hidden populations including undocumented, immigrants and refugees. In general, these populations are not seeking routine and preventive care due to both perceived and actual barriers, which contributes to poor health outcomes and a greater burden on the health care delivery system. Significant health disparities are documented with African American/Black and Hispanic populations experiencing dramatically poorer health status. While the overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks, there remain a greater percentage of pregnancies among these teens when compared to white teens.

While there was no specific SPM developed for this priority need, the goal to reduce health disparities has been incorporated explicitly in two of the SPMs, e.g. the reduction of intentional injuries and infants whose mother received prenatal care in the first trimester. All of CT's MCH programs collect standardized racial and ethnic information of populations they serve with the overarching goal to monitor whether or not these programs are meeting the needs of all sub-populations.

/2008/ The PHI Branch convened an internal Health Disparities workgroup.//2008//

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

SPM to be determined. /2007/The language of this performance measure has been formalized by participating Region I states as "Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in Caring for Our Children: 'Center-based facilities that serve any child under 2 years of age shall be visited at least

once a month by a health professional with general knowledge and skills in child health and safety. Center-based facilities that are not open 5 days a week or serve only children 2 years and older shall be visited at least quarterly on a schedule that meets the needs of the composite group of children."//2007//

/2008/ This SPM was updated to reflect information that can be obtained from the database.

Please refer to the SPMs section//2008//

/2009/ ***There were no changes to the State Priorities.*** //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	41	43	56	60	55
Denominator	41	43	56	60	55
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Source: CY2007 CT DPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate follow-up. (For more info on CT's newborn screening procedures/data see also the detailed note with Form 6).

Notes - 2006

Source: CY2006 CTDPH Newborn Screening Program, Family Health Section. Most recent data June 2008.

Notes - 2005

Source: CY2005 CDPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate followup. (For more info on CT's newborn screening procedures/data see also the detailed note with Form 6)

a. Last Year's Accomplishments

CT successfully met this objective by assuring that 100% of infants screened as positive with condition(s) received follow-up to definitive diagnosis and clinical management. Of 42,261 infants born in CT in 2007, 99% received newborn screening (NBS) prior to discharge or within first week of life. All 3,039 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up. Of these, 55 were confirmed as disease cases and 908 Hemoglobin traits were identified.

Of 1,017 cases of unsatisfactory NBS specimens, all but 16 were resolved with receipt of a 2nd specimen. There were 5 CT State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets, and 1 of these infants was later screened by their primary care

provider. 342 infants with transfusions were followed by the tracking staff. Those babies who were transfused prior to the NBS blood test were tracked until a 90-day post-transfusion specimen was collected and tested for Hemoglobinopathies and Galactosemia.

NBS Program Laboratory and Tracking staff met monthly to discuss quality assurance, statistical reporting and emerging genetic issues. NBS staff met quarterly with the Genetics Advisory Committee to discuss current and emerging issues related to NBS, potential expansion, and proposed NBS legislative bills.

NBS staff provided education and TA to birthing facility health professionals, primary care providers, families, nurse midwives and general public. The following are additional activities of the NBS staff: participated in the Sickle Cell Disease [SCD] Counseling Certification Training held at Hospital For Special Care, and the NBS Sickle Cell and Hemoglobin Screening and Genetics and NBS in CT workshop. Genetic NBS website was reviewed and updated to reflect changes in the screening panel, and the current statistical information.

NBS staff served on regional workgroups including the New England Genetics Regional Collaborative (NEGC), New England Consortium of Metabolic Disorders, NERGG Board of Directors, New England Public Health Genetic Education Collaborative (funded by HRSA) which included families who have children identified with genetic/metabolic disorders, and workgroups involved with transition (pediatric to adult) and the development of a regional NBS brochure and translation into 15 languages that was used as a regional model.

Regional Treatment Center Genetic Specialists provided NBS educational programs through grand rounds conferences throughout CT. Staff partnered with the Hospital for Special Care SCD to develop a needs assessment to identify gaps in services and developed plan for providing a comprehensive system of care for those with SCD and Trait . The plan was posted on the DPH's website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the quarterly Genetics Advisory Committee(GAC) meetings				X
2. Work with other groups to provide education on Genetics and NBS		X		
3. Screen all infants for selected metabolic or genetic disorders			X	
4. 4. Refer newborns with abnormal screening results for appropriate services			X	
5. Update educational programs to reflect the expansion of the NBS testing panel				X
6. Participate in various State, Regional, and National conferences				X
7. Support families identified with genetic and metabolic disorders		X		
8.				
9.				
10.				

b. Current Activities

DPH ensures early identification of infants at increased risk for selected metabolic or genetic disorders. NBS Tracking staff relocated to the State Laboratory; this relocation helps to ensure timely access to screening results. Staff continue to monitor legislative activity regarding the bill

proposing universal screening for Cystic Fibrosis.

The GAC Membership has been expanded to include the Citizens for Quality Sickle Cell Care, Hospital For Special Care, Southern CT Chapter of the Sickle Cell Disease Association of America and the DPH's Virtual Office of Genomics.

NBS staff participate on various Region I activities including: the New England Genetics Collaborative (NEGC), the New England Regional Genetics Group, Inc (NERGG) Board of Directors; the New England Public Health Genetic Education Collaborative - Newborn Screening Brochures were completed for 8 languages (7 pending) and assisted with the development of the New England Regional Genetics Resource Directory (NERGG, Inc. website).

c. Plan for the Coming Year

CT will assure that infants are screened for genetic disorders, adding other selected metabolic or genetic disorders to the screening panel when appropriate. All newborns with abnormal screening results will be referred to state Regional Treatment Centers for comprehensive testing, counseling, education, and treatment services so that medical treatment can be promptly initiated.

Quality improvement reviews will be conducted to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling and follow up services.

NBS staff will work collaboratively with the Genetics Advisory Committee (GAC), the specialty treatment centers, and others in the development and implementation of educational materials and programs. DPH will enhance its website with additional information and explore other opportunities for web-based educational programs. NBS staff will continue to participate and collaborate on the implementation of the CT Genomics Action Plan.

If the legislative bill proposing the addition of Cystic Fibrosis to the NBS panel is passed, NBS staff will revise guidelines, protocols, brochures, and fact sheets to reflect the change. If this occurs, NBS staff will prepare for an increase in staff to include an additional Nurse Consultant and a Health Program Associate.

Staff will participate in the HRSA grant awarded to the New England Genetics Collaborative, (NEGC). CT DPH will collaborate with the NERC and will seek other funding opportunities to address the program's genetic, NBS and long term follow up for infant and children's treatment needs and family care concerns. Staff will also participate on the New England Consortium of Metabolic Disorders Group, the New England Regional Genetics Group (NERGG) and various other New England projects and programs.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8
Annual Indicator	59.8	59.8	59.8	59.8	57.8
Numerator					

Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This measure was not met since there was a 2% decrease from the 2001 SLAITS survey (57.8% in 2005-06 SLAITS vs. 59.8% in 2001 SLAITS). CT, however, does remain slightly higher than the national figure of 57.4%. The RMHSC and Regional Family Support Network (RFSN) worked together to expand the level of support, information, referral and networking available to families throughout CT. The Family Support Council list serve provided information about local and statewide services and was utilized to provide creative solutions for needed services and supports. RFSN hosted family forums to share resources in order to better serve families of CYSHCN statewide.

Request for Proposals were made to transition care coordination and services for CYSHCN from the RMHSC towards more community based, culturally competent medical homes in accordance with recent trends and direction from the Medical Home Advisory Council. The implementation of the new model of services, The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs, began July 1, 2007. Contractors were selected and provided services in management of extended services and respite funds; care coordination; and provider/family education and family support. The transition of services to the new model resulted in an increase from 2,105 to 2,820 CYSHCN served.

Child Health and Development Institute (CHDI), the contractor for provider/family education works with pediatric primary care settings to survey for knowledge regarding the concept of medical home and/or assistance with establishing or linking with medical homes for the targeted population and implemented culturally appropriate training for families and providers.

Families continued to be active members of the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices. DPH compensated families to review CT's Title V MCH Block Grant and invited families to submit written comments on the MCHBG application.

Families continued to participate and were compensated for their work on the Medical Home Advisory Council. A family member from the Council was nominated and awarded a family scholarship to the Association of Maternal and Child Health Programs (AMCHP) National

Convention in Washington D.C. The DPH Family Advocate was sponsored by DPH to attend the national conference as well.

Eight family representatives served as voting members of the Medical Home Advisory Council and established three workgroups including a Family Experience workgroup. DPH provided stipends to assist families to participate on either Council and/or work group activities. Families also continued their work on the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices.

DPH participated as a partner in the management team overseeing the Family-to-Family (F2F) Health Information Network and provided funding to create a tool kit of health information for families and providers. The RMHSCs played an active role by working with the F2F-Family Health Information Network to provide information and resources to Medical Home practices. The Network assisted families in negotiating the complex system of health services and health care access, including funding and reimbursement.

DPH monitored, enhanced and revised the statewide respite system available through the RMHSCs. DPH distributed the Get Creative About Respite manual through community activities, and created and disseminated Directions: Resources for Your Child's Care an information organizer for families, available both in hard copy and electronically through the DPH website that includes sections on Medical Home, health plan information, transition, connecting parents and families.

DPH, through the RMHSCs and Medical Homes, distributed an Access database to manage and report information on CYSHCN served by Title V. The system allowed DPH to collect information from families to support CYSHCN program surveillance, planning and evaluation.

The DPH Family Advocate was available to all Maternal and Child Health Programs within DPH, the RMHSCs, Medical Homes and the Regional Family Support Network.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage families to participate in Family Forums, RMHS meetings, Medical Home Advisory Council, Block Grant review, Family Support Council and meetings as appropriate				X
2. Support families to participate through training and mentoring and compensate for time and knowledge				X
3. Provide trainings for families on statewide and local supports, link families to existing trainings and other resources				X
4. Have families provide training for all stakeholders and encourage sharing lessons learned				X
5. Assure families from diverse backgrounds are involved				X
6. Distribute family surveys		X		
7. Assure establishment and growth of family/professional partnerships				X
8. Provide families with tools such as "Get Creative About Respite" and "Directions"		X		
9.				
10.				

b. Current Activities

DPH supports and enhances the family-centered Medical Home concept in CT through the Child Health & Development Institute (CHDI) and their subcontractors, the UConn Center of Excellence in Developmental Disabilities and the Family Support Network, who provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for CYSHCN.

These services include providing assistance and culturally appropriate education to families of CYSHCN that will enable them to acquire skills necessary to access needed medical and related support services. Families learn to link to these services and become empowered, competent supporters for their children. CHDI and their subcontractors distributed a survey to families to collect information about the care their CYSHCN receive from their pediatrician or PCP.

DPH promotes the partnering of families in decision making for CYSHCN through compensation for families to review CT's MCHBG application, participate in the MCH focus groups, and the distribution of Get Creative About Respite and Directions: Resources for Your Child's Care manuals.

The MHAC formed a Family Experience Workgroup for the purpose of gathering input from families and to prepare the 7 voting representatives of the Council to more fully participate in the Council meetings. Teleconferencing is available for families who cannot attend in person, stipends are provided and meetings focus on the CYSHCN NPMs.

c. Plan for the Coming Year

The DPH will support and enhance the family-centered Medical Home concept in CT through the Child Health and Development Institute (CHDI) and their subcontractor the Family Support Network (FSN). The CHDI and their subcontractors will collect survey results from families and providers and share with DPH and interested stakeholders.

DPH has partnered with key stakeholders to respond to a Health Resources Services Administration (HRSA) grant for a second level of funding for the CT Family-to-Family Health Information Network. The project will build upon the accomplishments of the existing Network and will assist families and providers in navigating the public and private health care financing service delivery systems and to develop appropriate strategies and policies to improve these systems. Through the Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs, care coordinators will continue to play an active role by working with the F2F-Family Health Information Network to provide information and resources to Medical Home practices.

DPH has recently been awarded the HRSA State Implementation Grant for integrated community systems and will implement grant activities to include partnering with key stakeholders including the following family and consumer agencies: CT-KASA (Kids As Self Advocates), Parent to Parent of CT, Parents Available to Help (PATH), and Family Advocacy for Children's Mental Health, Inc. (FAVOR). Grant activities will include the establishment of a MHAC Youth Workgroup through CT-KASA, who will provide the Council with youth perspectives and consultation. The partnering family and consumer agencies will identify family and youth representatives to participate in a medical home learning collaborative.

DPH will identify grant funding to assist in the continuous building of strong family/professional partnerships in CT.

Families will be active members of the MHAC, the MHAC Family Experience workgroup, the Medical Home Advisory Council Quality Indicators workgroup, the Medical Home Advisory Council Finance workgroup, the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices.

DPH will promote the partnering of families in decision making for CSHCN. These activities include but not be limited to: compensation for families to review CT's Title V Maternal and Child Health Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, distribution of the Get Creative About Respite and Directions: Resources for Your Child's Care manuals, provision and support of an Access database to manage and report information on CYSHCN, and partnership in the Family-to-Family (F2F) Health Information Network management team.

The DPH Family Advocate and Consumer Information Representative remain available to all DPH MCH Programs, Medical Homes, and the Family Support Network.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	56.9	56.9	56.9	56.9	56.9
Annual Indicator	56.9	56.9	56.9	56.9	48.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	48.5	48.5	48.5	48.5	48.5

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Annual performance objectives for 2008-2012 were updated using this more recent data.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the SLAITS Survey have pre-populated the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This objective was successfully met using a comparison of the CT 48.5% vs. the national 47.1% reported in the 2005-06 SLAITS. (Changes in the question formats does not allow comparisons to the 2001 SLAITS). DPH assessed and implemented the Regional Medical Home Support Centers (RMHSCs) to enable Children and Youth with Special Health Care Needs (CYSHCN) to receive coordinated, ongoing, comprehensive care within a medical home.

DPH assisted the RMHSCs to develop a medical home provider network through outreach

materials for presentations. DPH worked with the RMHSCs and medical homes to facilitate family-professional partnerships and engaged parent partners to connect families with support services and share information about statewide and community supports through forums as well as electronically through a list serve.

The Medical Home Advisory Council (MHAC) implemented their long-term comprehensive plan to improve the community-based system of care for CYSHCN.

Request for Proposals were made to transition care coordination and services for CYSHCN from the RMHSC towards more community based, culturally competent medical homes in accordance with recent trends and direction from the Medical Home Advisory Council. The implementation of the new model of services, The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs, began July 1, 2007. Contractors were selected and provided services in management of extended services and respite funds; care coordination; and provider/family education and family support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative.				X
2. Assist the CT Medical Home Initiative with developing a medical home provider network.				X
3. Work with CT Medical Home Initiative and the Family Support Network to facilitate family-professional partnerships.				X
4. Disseminate Medical Home Academy curriculum.				X
5. Participate on Medical Home Advisory Council and workgroups.				X
6. Provide families with tools such as "Get Creative About Respite" and "Directions."		X		
7. Implement medical home pilot program.				X
8.				
9.				
10.				

b. Current Activities

DPH supports medical homes through a contract with CHDI, to provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical homes. To date, 10 pediatric providers have received training/information regarding medical homes.

DPH implements and provides TA for care coordination activities associated with the CT Medical Home Initiative for CYSHCN through contracts with the Hispanic Health Council, St. Mary's and Stamford Hospitals, Coordinating Council for Children in Crisis, Inc., and United Community and Family Services, Inc., to provide culturally competent care coordination services in community-based pediatric practice settings for families. Care coordinators are co-located in pediatric practices and work in partnership with pediatric clinicians and families in accessing needed services. Services include: care coordination for medical homes as requested by families or providers, coordinate interagency activities, provide assistance to families to help them navigate systems to obtain needed services, family education, home assessments, develop and maintain linkages with specialists and other health care resources. Care coordination services are provided at 26 community based medical homes.

In response to a legislative mandate, and in consultation with the Medicaid managed care organizations administering HUSKY A Plans, a medical home pilot Program was initiated.

c. Plan for the Coming Year

DPH will provide training and technical assistance to ensure that the medical homes are providing coordinated, ongoing and comprehensive care for Children and Youth with Special Health Care Needs.

The five medical home contractors associated with Children and Youth with Special Health Care Needs program will ensure the availability of care coordination services at the community based medical homes. The community based medical home pediatric practices will be expanded from 26 sites to increase the availability of care coordination services to CYSHCN and their families.

The Medical Home Advisory Council (MHAC) will implement their comprehensive long-term plan to improve the system of care, including progress made through it's workgroups (Family Experience, Quality Indicators and Finance) to further assist CT's children and youth with special health care needs.

CHDI, the contract awardee for statewide outreach and culturally competent education will work with pediatric primary care providers and families with pediatric primary care settings to survey for knowledge regarding the concept of medical home and /or assistance with establishing or linking with medical homes for the targeted population, surveyed families, and conduct culturally appropriate training for families and providers.

DPH will implement the medical home pilot program in three practice sites (these are in addition to those identified above) in Waterbury, Hartford and Stamford. The aim of the pilot is to increase EPSDT services and to build care coordination capacity at the sites in order to enhance health outcomes for children, including children with special health care needs. The Commissioner of Public Health will provide a report to the General Assembly outlining the specific improved health outcomes and any cost efficiencies achieved by the pilot project one year after the pilot's inception.

DPH will implement HRSA State Implementation Grant for Integrated Community Systems for CSHCN activities. Activities will include a Learning Collaborative based around transition for YSHCN in medical homes and will engage five community-based pediatric medical homes and five adult providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	61.3	61.3	61.3	61.3	61.3
Annual Indicator	61.3	61.3	61.3	61.3	61.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	61.7	61.7	61.7	61.7	61.7

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual performance objectives for 2008-2012 were updated using this more recent data.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS survey have pre-populated the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This objective was successfully met as evidenced by the reported 2005-06 61.7 % vs. the 2001 SLAITS 61.3%. The Connecticut System of Care for CYSHCN entitled "Regional Medical Home Support Center (RMHSC) System of Care for Children and Youth with Special Health Care Needs," was transitioned from a support center to a community model and recruited primary care practices (medical homes) to identify children with special health care needs (CSHCN) utilizing the CAHMI Screener(c) to identify the complexity involved in supporting CSHCN. Care coordinators at the RMHSCs/medical homes supported coordination of services for children/youth/families referred by primary care providers.

Requests for proposals were made to transition care coordination services for children and youth with special health care needs from the Regional Medical Home Support Centers towards more community based, culturally competent Medical Homes in accordance with direction from the Medical Home Advisory Council. Implementation of the new model of services, The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs, started July 1, 2007. Contractors were selected and provided services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. A memorandum of agreement to support the transition of the system was put in place with The Children's Trust Fund.

The care coordination, as well as the extended services and respite fund manager contract grantees, provided benefits coordination for families of CYSHCN to assist in accessing public/private sources to pay for services needed including the facilitation of eligibility determination and application for Healthcare for Uninsured Kids and Youth (HUSKY). Under HUSKY, children and youth up to age 19 receive a comprehensive health care benefits package, including preventive care, physician visits, prescriptions, vision care, dental care, physicals, mental health and substance abuse services, durable medical equipment, emergency and hospital care.

DPH staff represented Connecticut's Public Health Commissioner at the Connecticut Medicaid Managed Care Council. The Medicaid Managed Care Council was established as a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid (HUSKY Part A) and SCHIP (HUSKY Part B) Managed Care program and for ongoing legislative and public input in the monitoring of the program.

The number of participants in the Katie Beckett Waiver was expanded from 180 to 200. The Katie Beckett Waiver enables severely disabled children to receive an institutional level of care at home and bases eligibility for Medicaid on income and assets without counting the income and assets of legally liable relatives (parents), thereby providing access to public insurance for highly complex CYSHCN who would not have been eligible due to family income.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess family's insurance status.		X		
2. Provide education on benefits/services provided by insurance/other programs.				X
3. RMHSC and Medical Homes identify CYSHCN and provide care coordination including access to private/public insurance.		X		
4. Coordinate with HUSKY Infoline.		X		
5. Work with Medicaid Managed Care Council and DSS to ensure CYSHCN population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The contractors for care coordination services are enhancing the statewide implementation of the system to serve families of CYSHCN with comprehensive, accessible, coordinated care including access to adequate public and private insurance to pay for family services.

In response to a legislative mandate, DPH, in consultation with the Medicaid managed care organizations administering HUSKY A Plans, is conducting a medical home pilot program to enhance health outcomes for children, including CYSHCN. One year from inception of the project, the DPH Commissioner will report specific improved health outcomes and cost efficiencies achieved to the General Assembly.

A forum was held on March 27, 2008 for contract grantees and families associated with the Medical Home Initiative for Children and Youth with Special Health Care Needs. Staff from the Department of Social Services Bureau of Rehabilitation Services (DSS/BRS) and the Department of Developmental Services (DDS) presented information concerning eligibility requirements for supports and services for CYSHCN available through those agencies including eligibility for Medicaid and waiver programs. Eligibility and application for the Katie Beckett Waiver was emphasized and issues pertaining to undocumented citizens were discussed.

A forum was held in May regarding financial estate and trust planning for CYSHCN including ongoing access to private insurance. Medical home care coordinators and 16 families attended the forum.

c. Plan for the Coming Year

To address the public and private insurance needs of Youth with Special Health Care Needs (YSHCN), Title V Children and Youth with Special Health Care Needs Program will continue the integration and improvement of strategies for CYSHCN and their families in accessing public/private sources and to continue assisting families with eligibility determination and application for HUSKY A and B.

CYSHCN contractors will provide care coordination services for those clients transitioning to adulthood including obtaining maximum benefits under respective health insurance plans and/or if enrolled in HUSKY A and Medicaid to obtain medically necessary services.

The Connecticut Lifespan Respite Coalition, the contract grantee for the management of Extended Services and Respite funds will provide assistance to families in accessing existing insurance benefits and will assist in the process of filing appeals when claims are denied.

The Family Experience Workgroup of the CT Medical Home Advisory Council dialoged around the inadequacy of their insurance to pay for needed services for CYSHCN and reviewed preliminary findings of a Family Survey conducted by CHDI. Once survey results are compiled and further discussions take place, the workgroup will focus their efforts on the results as a need for the workgroup to revisit this topic in greater detail has been identified.

Additional forums with a focus on providing medical home care coordinators and families with continuous updates on insurance options and accessing public/private sources to pay for services will be held.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	76.8	76.8	76.8	76.8	76.8
Annual Indicator	76.8	76.8	76.8	76.8	89.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	89.4	89.4	89.4	89.4	89.4

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Annual performance objectives for 2008-2012 were updated using this more recent data.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS Survey have pre-populated the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This objective was successfully met using a comparison of the CT 89.4% vs. the national 89.1% reported in the 2005-06 SLAITS. (Changes in the question formats does not allow comparisons to the 2001 SLAITS). The Connecticut Title V System of Care for Children and Youth with Special Health Care Needs (CYSHCN) Regional Medical Home Support Centers (RMHSCs) enabled children and youth with special health care needs to receive coordinated, ongoing, comprehensive care in their local communities. The goals of this community-based system of care were: 1) reach more CYSHCN and their families and assist them with coordination of the multiple systems of care they need to access; 2) provided training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that will optimize the health of CYSHCN; 3) assisted pediatric PCPs with care coordination for CYSHCN who have high severity needs; 4) assisted with coordination between pediatric PCPs and specialists; and 5) promoted the establishment of "medical homes" with pediatric PCPs that care for CYSHCN.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to implement a referral and coordination of services system to assess and refer CYSHCN and their families to RMHSCs. During this year, CDI provided additional care coordination support in regions requiring technical support.

The Medical Home Advisory Council developed a long-term comprehensive plan to improve the community-based system of care for CYSHCN. As a result of this long-term plan, requests for proposals were issued to transition from the Regional Medical Home Support Centers towards a more community-based, culturally competent medical home approach. The new model of services began July 1, 2007. Contractors provided services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. The new model of services resulted in an increase of 715 CYSHCN served last year, from 2,105 to 2,820.

The Department maintained public/private partnerships with organizations that serve CYSHCN and their families. DPH staff participated on legislated councils, Connecticut Family Support Council, Medicaid Managed Care Council, Birth to Three Interagency Coordinating Council, State Department of Education Bureau of Special Education Transition Task Force, and National Governor's Award Task Force on Transition of Youth with Disabilities to Work.

DPH staff disseminated Directions: Resources for Your Child's Care an information organizer for families, available both in hard copy and electronically, that includes sections on medical home, health plan information, emergency preparedness, transition, and connecting parents and families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative for Children and Youth with Special Health Care Needs				X
2. Implement, monitor and evaluate referral and coordination of				X

services system with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline				
3. Develop and release requests for proposals to expand the medical home concept throughout Connecticut.				X
4. Work with contractors to survey families regarding access to community-based service systems.				X
5. Develop trainings to enhance families ability to access community-based service systems.				X
6. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families				X
7. Implement recommendations from Medical Home Advisory Council strategic planning process				X
8.				
9.				
10.				

b. Current Activities

DPH promotes an accessible, community based medical home concept. Child Health & Development Institute and the Family Support Network provide outreach and culturally effective education to pediatric primary care providers and families including information regarding accessing systems. The FSN provided information to 756 families who are enrolled in the medical home program.

Five medical home networks provide services as follows: the Stamford Health System serving Southwest CT, Saint Mary's Hospital (Northwest CT), United Community & Family Services, Inc. (Eastern CT), the Coordinating Council for Children in Crisis (South Central CT), and the Hispanic Health Council (North Central CT). Each network is affiliated with and provides imbedded care coordination to numerous clinical sites. Care coordination is co-located in 26 pediatric practices, making care coordination services easier to access for families. This community-based system is projected to serve more than 4,300 CYSHCN this year.

DPH monitors the system of care to ensure CYSHCN receive coordinated, ongoing, comprehensive care in their local communities.

DPH collaborates with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the community-based system.

A Family Experience Workgroup was convened and meets on a regular basis. Families who participate on this workgroup provide ongoing input into the medical home program, including the ease of use of services by families.

c. Plan for the Coming Year

DPH will advance the family-centered medical home concept in Connecticut. CHDI and its subcontractors will provide statewide outreach and culturally effective education to pediatric primary care providers and families on the concept of medical home for CYSHCN including access to a community-based service system. CHDI through its subcontractors will distribute and collect surveys about the care that a child or adolescent with special health care needs receives from his/her pediatrician or primary care provider including information about community-based service systems.

Family support services will provide assistance and culturally effective education to families of CYSHCN to enable them to acquire the skills necessary to access needed medical and related support services. Survey results will be utilized to design trainings to promote learning on how to

link to community-based supports.

DPH will monitor and evaluate the Connecticut Medical Home Initiative for CYSHCN which promotes a community-based system of care to enable CYSHCN to receive coordinated, ongoing, comprehensive care in their local communities.

DPH will collaborate with United Way of CT 2-1-1/Child Development Infoline to coordinate referrals for CYSHCN and their families to the community-based service systems including referrals to the Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs.

DPH will maintain public/private partnerships with other organizations that serve CYSHCN and their families. The Medical Home Advisory Council will implement and evaluate the long-term comprehensive plan to improve the community-based system of care for CYSHCN.

The Family Experience workgroup will meet every other month. Information from the workgroup will be brought to the MHAC for further discussion and action. Ongoing information from this workgroup will also be formally captured for the upcoming five-year needs assessment.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	43.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	43.3	43.3	43.3	43.3	43.3

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Adjustments to the annual performance objectives were made for 2008-2012 because of the wording changes to this measure. Adjustments used CT's 2007 figure which is higher than the national % for this measure.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS Survey have pre-populated the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This measure was successfully met (CT 43.3% vs national 41.2%). DPH implemented an Access database to manage and report information on children and youth with special health care needs (CYSHCN) & to provide demographic and care coordination information to support CYSHCN program surveillance, planning and evaluation.

The database provided data on the number of YSHCN in the state system prompting DPH to expand its statewide efforts to promote Regional Interagency Care Coordination Collaboration for Youth with Special Health Care Needs (YSHCN) in Transition. These regional collaborations focus on improved interagency coordination of successful transition to all aspects of adult life for YSHCN.

Pediatric/adolescent/family practice primary care providers (PCP) interested in practicing successful YSHCN health care transition were identified. The Connecticut Medical Home Initiative for CYSHCN's training module entitled "Medical Home and Transitions: Growing Up and Moving On" presented by Dr. Karen Rubin was made available to these practitioners. The module was designed for individual or group professional education and also in distance learning format on the DPH website.

DPH Care Coordination Contractors assisted primary care providers in identifying YSHCN 14 years and older in their practices and encouraged development of interagency transition plans. Care coordinators made available, Directions: Resources for Your Child's Care, an information organizer for families, available both in hard copy and electronically (through the DPH website). It includes sections on medical home, health plan information, transition, and connecting parents and families.

CT expanded youth and family partnership in the statewide system process of transition to a meaningful and productive adult life. This work included: advancing achievement of the six YSCN Performance Measures; membership on the Connecticut DPH Medical Home Advisory Council (MHAC); advisement on initiating a quality assurance process to identify YSHCN who receive desired services and supports by age 21; and YSHCN transition resources.

CT worked actively with national groups such as Healthy and Ready to Work (HRTW) to further enhance their infrastructure building to achieve successful transition to all aspects of adult life for YSHCN. Meeting with key YSHCN healthcare providers continually identified the importance of personal health as a critical component in the developmental stage of transition.

DPH and their Care Coordination Contractors partnered with state agency regional offices to develop & distribute transition resources to YSHCN and their families/caregivers as well as service providers. These resources included: BUILDING A BRIDGE From School To Adult Life For Young Adults With Disabilities In Connecticut; Transition Planning for Adolescents with Special Health Care Needs and Disabilities: Information for Families and Teens; A Directory of Transition Programs in College, University or Community-Based Settings in Connecticut and the CT School to Work Transition.

DPH routinely brings the importance of health care transition to the agenda of youth transition strategic planning groups. DPH actively participates on the State Department of Education Transition Task Force. This is a statewide interagency council which advances the coordination of the transition needs of youth with special needs. DPH was actively engaged as a member of the interagency council working on the National Governor's Award to Connecticut to target youth with an identified disability between 16 - 22 years of age that are transitioning into adulthood and

employment. This culminated in the development of a youth friendly resource map website.

DPH implemented the transition care coordination and services for children and youth with special health care needs from regional support centers towards more community based, culturally competent Medical Homes in accordance with recent trends and direction from the Medical Home Advisory Council. This new model of services commenced July 1, 2007. DPH applied for and received MCHB technical assistance funds to support focused transition planning and facilitation as part of a new contract grantees orientation meeting held in June 2007. The meeting included presentations from Patti Hackett, Co-Director, Healthy and Ready To Work National Resource Center and Patience White, MD, FAAP, MA, Medical Home and Transition Advisor.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify youth with special health care needs.			X	
2. Identify and strengthen relationships with schools, community-based organizations and State Agencies.				X
3. Provide children and families individualized transition packets.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH promotes successful YSHCN transition and provides culturally competent education on the medical home concept, including the importance of transition planning. CHDI has presented to ten pediatric practices.

"Transition to Adulthood: A Critical Milestone" hosted by DPH and United Way of Connecticut/2-1-1 Child Development Infoline, in partnership with CT-Kids As Self Advocates, was attended by 140 young adults, families & providers. Information and resources included transition from pediatric to adult medical/behavioral health services, and school to work. Patti Hackett & Patience White, MD provided the keynote address "Transition to Adulthood for CYSHCN: Preparing for the Difference." The workshop included a discussion "Sickle Cell Disease: A Family Perspective".

DPH partners in multiple youth interagency projects to resolve lack of coordination and programming for young adults transitioning to independence. DPH involvement raises awareness of the need to incorporate health in transition plans.

DPH and CT Comprehensive Sickle Cell Disease Consortium introduced "Designing a Comprehensive System Across the Lifespan: Connecticut's State Plan to Address Sickle Cell Disease and Trait", along with media awareness campaign "Face Sickle Cell". The Consortium implements SCD lifespan prevention initiatives and interventions.

The DPH sponsored workshop, "Aging Out of Title V" was attended by all DPH care coordination contractors and eight Family Support Network families.

c. Plan for the Coming Year

The contract grantee for provider and family outreach and education, Connecticut Child Health and Development Institute (CHDI) will provide statewide culturally competent education for pediatric primary care providers and families on the concept of medical home for youth with special health care needs and link these youth to medical homes, when available, as well as support services.

DPH Care Coordination Contractors will expand upon the Statewide Interagency Care Coordination Collaboration for Youth with Special Health Care Needs (YSHCN) in Transition. Increasingly, this will occur at the regional and local level to identify YSHCN 14 years and older and assist them and their families with developing an interagency transition plan.

Contractors will expand efforts to identify and educate pediatric/adolescent/family practice primary care providers (PCP) interested in practicing successful YSHCN health care transition. These providers will be encouraged to become medical homes. This process will be facilitated by offering providers the Connecticut Medical Home Initiatives for CYSHCN EPIC training module, 'Medical Home and Transitions' available for individual or group professional education.

Connecticut will expand inclusion of youth and family partners in the system process of transition to a meaningful and productive adult life. DPH and its contractors will expand identification of youth and family advocacy groups to collaborate in this work to include: achieving the six YSHCN Performance Measures; membership on the Connecticut DPH Medical Home Advisory Council (MHAC); advisement on initiating a quality assurance process to identify YSHCN who receive desired services and supports by age 21; and YSHCN transition resources.

DPH recognizes the need to promote the successful transition of YSHCN and will research additional resources to support the process to promote the successful transition of YSHCN.

DPH has been awarded the HRSA State Implementation Grant for Integrated Community Systems for CSHCN and will implement grant activities. Grant activities will focus on transition to include establishing of a Youth Transition Coordinator position within the DPH CYSHCN program, forming of a learning collaborative around transition, and developing a transition based medical home training curriculum.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	82	91.4	92.8	88.2	88.6
Annual Indicator	91.1	92.4	87.8	81.8	
Numerator	78103	79216	74327	67594	
Denominator	85734	85732	84655	82633	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012

Annual Performance Objective	89	89.4	89.8	89.8	90.2
------------------------------	----	------	------	------	------

Notes - 2007

Source: As of 2005, the new benchmark for childhood immunization coverage that will be measured nationally will include one dose of varicella vaccine for the first time.

Notes - 2006

Source: The NIS survey measurement changed in 2005 to capture varicella (chicken pox vaccine coverage). In 2005, for Immunization Performance measure, we still reported data from the NIS survey for the 4:3:1:3:3 coverage rate (4 DTap, 3 Polio, 1MMR, 3 Hib and 3 Hep B). In 2006, the benchmark for childhood immunization coverage that the National immunization Survey (NIS) measured added varicella vaccine to the list of vaccines. The 2006 benchmark became 4:3:1:3:3:1 with inclusion of varicella to the series. The addition of varicella resulted in a drop off in coverage rates. However based on this new standard, CT nationally still ranked 3rd in the country last year among all fifty states.

There is no indication that family fears regarding vaccines and autism has had any impact on these coverage rates.

Notes - 2005

Source: See website: www.cdc.gov/nip/coverage/nis/04/tab02antigen_state
CDC NIS data Q12004-Q42004 survey for 4: 3: 1: 3: 3:.. CT ranks among the top 3 states for immunization success rate. Denominator represents CY2001-2002 resident births. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 2/01-5/03.

a. Last Year's Accomplishments

CT did not meet the annual objective in 2006. In 2006, the benchmark for childhood immunization coverage measured by the National immunization Survey (NIS) added varicella vaccine to the list of vaccines. The 2006 benchmark became 4:3:1:3:3:1 with inclusion of varicella to the series. The addition of varicella resulted in a drop off in coverage rates. However based on this new standard, CT still ranked 3rd in the country last year among all fifty states. A number of Title V funded and non Title V programs promote age appropriate immunizations. There is no indication that family fears regarding vaccines and autism has had any impact on these coverage rates.

Right From The Start, Comadrona, Healthy Start and Healthy Choices for Women and Children provided case management to pregnant women and their children, monitored, encouraged and educated parents regarding the importance of keeping well child care visits. The programs assessed immunization status and linked children with primary care providers to maintain up-to-date immunizations. All Community Health Centers follow national guidelines for administration of childhood immunizations. Chart reviews are used to assure that infants and children are in compliance.

The CYSHCN program assessed children for required immunizations and referred them to appropriate resources. Care coordination is used to support families in accessing services, which includes assuring the receipt of timely immunizations.

The WIC Program encouraged parents and caregivers to obtain well childcare and referred participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program provided funding to support the Connecticut Immunization Registry and Tracking system (CIRTS) and 16 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consisted of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for

children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and provide training and support to medical providers who utilize the CIRTS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor infants and children for compliance with immunization schedules				X
2. Outreach and identify infants and children for up to date immunizations		X		
3. Provide support, information and linkage to necessary services		X		
4. Procure and provide publicly purchased vaccines		X		
5. Provide funding and technical support to health care providers to improve childhood immunization levels				X
6. Provide WIC check box to identify up to date immunization status			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program will provide funding to support the Connecticut Immunization Registry and tracking system (CIRTS) and 16 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consist of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and providing training and supporting medical providers who utilize the CIRTS.

All Title V programs (CYSHCN, case management programs for pregnant women) assess the immunization status of the infants/children and refers them as necessary to their medical home/primary care provider for any needed immunizations. Those without a designated primary care provider are referred to community health centers.

c. Plan for the Coming Year

The immunization program will 1) continue to assess and monitor immunization rates including HEDIS (Health plan Employer Data and Information Set) immunization rates for children enrolled Medicaid Managed Care; 2) have a web-based registry application deployed with 25% of pediatric providers on-line and 95% actively using the new web-based registry (CIRTS -- CT Immunization Registry and Tracking System) to input immunizations real-time for all of their patients under age six by the beginning of 2009; 3) convene local advisory/planning groups in all 16 Immunization Action Plan funded sites to improve immunization services for children in high risk areas; 4) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety; and 5) strive to achieve the Healthy People 2010 goal of enrolling > 95% of children under age six in our immunization registry.

The case management programs for pregnant women (and their children), will ensure that the

children are current with their immunizations and refer to the medical home/primary care provider as necessary to ensure compliance. All other Title V programs (CYSHCN) will also assess and provide care coordination for families to ensure immunizations are current.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	14	14	12.9	12.8	12.3
Annual Indicator	12.9	12.8	12.3	12.3	
Numerator	906	917	909	914	
Denominator	69976	71623	74155	74323	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	12.2	12.2	12.1	12.1	12

Notes - 2007

The CY2007 Vital Statistics data are not available.

Notes - 2006

Source: The CY2006 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.

Annual performance objectives for 2008-2012 were updated using this more recent data.

Notes - 2005

Source: CY2005 final data, CDPH, Vital Statistics

We do not anticipate having final 2005 and provisional 2006 data until a year from now. The 2006 annual objective field is "locked in" from last year and will not allow us to change the objective to reflect our most recent experience. If we were able to change this field we would have modified the objective for 2006 to read 12.3 NOT 12.8 which would be a goal in the OPPOSITE direction to an improved experience.

a. Last Year's Accomplishments

CT did meet this measure in 2006 with a slightly lower rate (12.3) than the annual performance objective of 12.8. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3. Note that the rate has remained the same for 2005 and 2006 but we hope that the trend toward decreasing the rate continues.

One major focus of last year's activities was the provision of continuing education opportunities to key stakeholders, especially on subjects related to best practices in teen pregnancy prevention, counseling, and asset-based approaches to engaging youth in health promoting behaviors. A

SBHC APRN was offered a scholarship to attend a multi-day conference focused on reproductive health. In collaboration with the John Snow Institute (JSI), a workshop was held in May 2007 entitled, "Best Practices in Teen Pregnancy Prevention -- Designing, Promoting and Evaluating Programs that Work." Approximately 75 participants attended. JSI continued to provide TA to certain attendees who desired to move forward with efforts to support a community-based approach in the prevention of teen births. In effort to reach non-traditional partners in promoting positive youth development, two workshops were also held in May to disseminate information on communication strategies that build public support for healthy youth development. Glynis Shea, Communications Coordinator from the Konopka Institute, presented. Over 75 individuals attended representing: health care providers, educators, faith based organizations, the Department of Labor, insurance companies, and many youth service organizations - including Park and Recreation Departments. The event offered networking opportunities for groups that traditionally do not work together on a day-to-day basis.

Collaboration continued with one of our key partners, State Department of Education (SDE). Planning focused on many major initiatives designed to prevent teen births in the state. Plans commenced to develop a workshop on science based approaches to teen pregnancy prevention. The target audience will be school health practitioners and educators. In addition, the Connecticut National Stakeholders Team met in February with AMCHP. During this TA visit, the CT Action Plan was revised. The Plan will help to drive future initiatives of the Stakeholder Team. In addition, the Department continued its partnership with SDE to promote the Coordinated School Health Model to school systems. The adolescent health coordinator continued to serve as a resource on issues related to teen pregnancy prevention both within the Agency as well as to community providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide risk assessments and referrals for reproductive health services			X	
2. Implement teen pregnancy prevention programs		X		
3. Collaborate with traditional and non traditional teen pregnancy prevention partners				X
4. Develop curriculum for addressing adolescent paternity for at-risk youth				X
5. Convene the interagency adolescent workgroup				X
6. Provide education opportunities to key stakeholders on best practices in teen pregnancy prevention and youth development				X
7. Establish an "Implementation Team" to address reproductive health and sexuality strategic issues identified as a priority in the State Adolescent Health Plan (activities will promote teen pregnancy, STD, and HIV prevention)				X
8.				
9.				
10.				

b. Current Activities

A conference was held entitled, "Making The Connections: Creating Partnerships to Develop and Implement Comprehensive Sexuality Education." The target audience included school health educators, administrators, nurses and local community based partners. Teen Health Guides were provided to SBHCs in middle and high schools. In addition, each SBHC site was given a new 3rd edition of the Bright Futures guides. Collaboration continues with National Stakeholders Group on projects to reduce risky behaviors affecting reproductive health outcomes. Potential initiatives

include a series of presentations to parents and grandparents at worksites to promote positive youth development and the development of a survey tool to capture current reproductive health-related activities in local education agencies.

Two goals were met from the Perinatal State Health Plan: DPH provided funding to DSS for a Region I Fatherhood Conference and MCHB funds have been secured to work with Doug Edwards, Executive Director of Real Dads Forever to develop a curriculum for fathers. Staff participate on the the Adolescent Paternity workgroup, made up of 7 state agencies targeting young males in DCF custody. One of the goals is to help young men make informed choices.

Funds from Right From the Start and Comadrone programs were blended and an RFP was released for a new case management program for pregnant women (including pregnant teens). The program selected in New Haven will be operated out of a High School.

c. Plan for the Coming Year

FHS staff will provide technical assistance and professional development to SBHC staff as they provide health education, risk assessments and referrals for reproductive health services. A new survey tool was developed to assist SBHCs in providing data for this Performance Measure. The SBHC Yearly Report now has questions specifically asking what activities address the following: teen pregnancy prevention, oral health, intentional and unintentional injury, access to health insurance, access to services in the SBHC and violence.

FHS staff will support professional development opportunities for both traditional and non-traditional partners to increase their capacity to utilize science-based approaches in teen pregnancy prevention.

The National Stakeholder team, as well as the CSHP teams, will be utilized to plan, implement and evaluate initiatives to support strategies outlined in the CT Action Plan (promoting teen pregnancy, STD and HIV prevention efforts). An awareness campaign targeting parents/grandparents to promote youth development will be implemented. Collaboration will continue with JSI and SDE to sponsor a teleconference targeting school nurses on the topic of Science Based Approaches (SBA) to teen pregnancy prevention.

Title V supported programs such as Healthy Start, Healthy Choices for Woman and Children, and the new case management program for pregnant woman will provide case management to pregnant women, including teens (both female and male).

The statewide Collaborative on Adolescent Paternity will design a second Rites of Passage program for next year. FHS staff will be an active member of the Adolescent Paternity Workgroup.

In partnership with the CT Chapter of the AAP, a teleconference is planned for September for health care practitioners and office staff on how to incorporate positive youth development into routine health care practices.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	26	30	30	30	12

Annual Indicator	26.0	26.0	26.0	11.4	38.0
Numerator	357	357	357	2984	1687
Denominator	1374	1374	1374	26171	4440
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	38	38	38	38	38

Notes - 2007

Source: The Office of Oral Health developed an oral health status report of children in Connecticut based on the results from oral health basic screening survey (Every Smile Counts) conducted in the 2006- 2007 school year of Head Start, kindergarten and third grade children. Only 38% of the third graders had dental sealants.

Note: The Annual Performance Objectives were updated beginning with 2008 based on the more recent data. The annual performance objectives were all set to 38% since it is unknown when the screening survey will be repeated. This objective was unable to be updated for 2007 since TVIS has this field locked.

Notes - 2006

Source: CT Voices for Children SFY06, HUSKY A population. Projections were made based on this data even though this data may not be representative of the population as a whole. Data from the state survey conducted this year should be available for next year's report.

Notes - 2005

Data for this measure requires a state survey of third grade children. CT has no new statewide data since the last such survey was funded SFY2000. There was a private regional survey conducted in NW CT this past year (2005) including 8 of our 169 towns. Data showed 47.5% of 3rd graders had received dental sealants. It should be noted that these towns were: a) more affluent than the rest of the state with a Per Capita Income(PCI) of \$36, 370 vs. \$28,766 for the state, and b) less diverse with only 3.4% non-white vs. 18.4% for CT as a whole.

a. Last Year's Accomplishments

CT successfully met this objective. The Office of Oral Public Health conducted the Connecticut Oral Health Basic Screening Survey, "Every Smile Counts", during the 2006 - 2007 school year. This survey is the first time that an open-mouth survey of the oral health status of Connecticut children was conducted to include children in Head Start, kindergarten and third grade from all eight counties throughout the state.

Seventy-six (76) schools and 20 Head Start Programs participated in the survey with more than 10,000 children screened for dental sealants, untreated caries, treated caries, rampant caries (5 or more untreated teeth) and need for urgent care.

Collaboration was developed with the University of Connecticut, the University of Bridgeport, School of Dental Hygiene and the Southwest Area Health Education Center to recruit and train the dental hygienists and recorders to conduct the survey. The findings of the survey were analyzed during the summer of 2007, and a report was developed. Funding from the MCHBG, the Connecticut Health Foundation and the Connecticut State Dental Association and Foundation supported this effort.

The Department obtained dental sealant data from the Department of Social Services for state fiscal year 2006. These data reflect the number of children in the HUSKY A Program with at least one dental sealant placed during that time. For children age 6 - 15 ever enrolled, 8.8% had at

least one sealant placed. For those aged 15, only 4.0% had at least one sealant placed and for the age group 6 - 8, 13.1% had at least one dental sealant.

The revision of the OPENWIDE training curriculum for non-dental providers was not completed this year due to the tremendous amount of work required to administer the Every Smile Counts Survey.

The Oral Health in Connecticut Report was finalized. It is an overview of the current knowledge about the state of oral health issues in Connecticut and is intended to provide the most up-to-date data on oral health. The information contained in this document will facilitate the future monitoring of trends and improvements in oral health of Connecticut residents. The Oral Health Improvement Plan 2007-2012, developed in collaboration with the CT Coalition for Oral Health Planning, was also finalized.

A statewide oral health conference will be held during the summer to update stakeholders on the status of various oral health activities, such as the dental sealant demonstration pilot grants, Every Smile Counts and the State Oral Health Improvement Plan.

Legislation proposed last year that would address a number of the goals contained in the Oral Health Improvement Plan did not pass. The state legislature has again proposed similar legislation this session (2006-2007) that would: (1) increase Medicaid reimbursement for dental services for children, (2) mandate an Office of Oral Public Health in state statute, and (3) establish regional oral health coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants' prevalence.				X
2. Continue OPENWIDE training of non-dental providers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health developed an oral health status report of children in CT based on the results from oral health basic screening survey (Every Smile Counts) conducted in the 2006-2007 school year of Head Start, kindergarten and 3rd grade children. 9,364 were screened to assess oral health status including the presence/severity of tooth decay (dental caries) and sealants. While the prevalence of tooth decay has declined in some children, dental caries remains a significant public health problem for CT's children. The highest level of dental disease and the lowest level of dental sealants were found in minority and low-income children. Only 38% of the third graders had dental sealants.

The Office distributed a Request for Proposal (RFP) for available bonding monies to enhance oral health care by developing or expanding dental facilities for underserved populations. Preference was given to applicants that targeted high-risk populations. Seventeen (17) applications were

received, and, six (6) proposals were recommended for funding.

The Office received a HRSA grant to develop a statewide infrastructure that will increase early childhood oral health interventions. The goals of the "Home by One" Program include increased coordination/exchange of oral health information with early childhood services, developing advocates, training non-dental providers, expanding the number of dental homes for children including CSHCN and promoting dental visits by age one.

c. Plan for the Coming Year

The Office of Oral Health plans on concentrating a great deal of its activities on the implementation of the Home by One program to develop a statewide infrastructure that will increase early childhood oral health interventions. These activities will demonstrate linkages of oral health to early childhood development, nutrition, readiness to learn, and overall health and well being with the target population being WIC children and their parents. These activities will include providing training to general dentists and their staff on the competencies and importance of an age one dental visit, the concept of a dental home and how to become one; training pediatricians in oral health risk assessments, anticipatory guidance and application of fluoride varnish; educating primarily WIC parents in oral health advocacy issues and the importance of proper disease prevention methods and a dental visit for their children by age one and providing in-services and oral health information using the Connecticut Department of Public Health's OPENWIDE curriculum to educate WIC staff on their role in and opportunities for early childhood oral disease prevention. Comprehensive evaluation tools will be developed to measure the effectiveness of the program activities and will be monitored closely. This will include the number of pediatricians and dentists trained and implementing its contents, the number of WIC children seeing a dentist by age one and having a dental home and the number of opportunities the parents trained in oral health advocacy had in actually utilizing these new skills in advocacy events.

In addition, the Office will work with one (1) WIC program in the state to demonstrate the effectiveness of a dental hygienist being on site at a WIC program. The hygienist will provide oral health education and information to staff and parents and oral health preventive services when practical. In addition, the hygienist will work to increase the awareness of age one dental visits, establish dental homes in the community and create referral systems to these dental homes by age one. The program will be required to monitor and report on the number of WIC parents and children receiving oral health education and information as well as the number of children who actually had a dental visit by age one.

The Office of Oral Health will be collaborating with the MCH Advisory Committee to conduct a fall conference on addressing the oral health needs of the MCH population. Oral Health staff are active members of the MCH Advisory Committee and are assisting in the recruitment of other dental providers to the committee.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0.7	0.7	0.9	1.5	1.4
Annual Indicator	1.5	1.9	1.6	0.8	
Numerator	11	13	11	5	
Denominator	734933	691876	682998	665901	

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	1.3	1.2	1.1	1	0.9

Notes - 2007

CY 2007 data are not available.

Notes - 2006

Source: CT Dept. of Public Health, HISR, CY 2006 final Vital Statistics.

The annual performance objectives are locked and although we see a dramatic decrease in this rate, we are unable to adjust the annual performance objectives.

It may also not be prudent to change the annual performance objectives as this single year data point in CY 2006 may be an outlier.

Notes - 2005

Source: CT Dept. of Public Health, HISR, CY 2005 final Vital Statistics.

a. Last Year's Accomplishments

In 2006, CT successfully met this measure with the decline from 11 deaths in 2005 to 5 in 2006, resulting in a rate that is almost half of the annual performance objective in 2006. The small numbers that are reported for this measure make the stability of the rate susceptible to random fluctuation. Connecticut addresses this National Performance Measure through Title V and non-Title V programs and collaborations that provide activities designed to reduce deaths and non-fatal injuries due to motor vehicle crashes.

The Injury Prevention Program, using MCHBG funding, developed a contract with Safe Kids Connecticut. Safe Kids conducted 18 child passenger safety workshops for families, healthcare, childcare and community service providers. The workshops served over 200 persons. Workshops for families included a program for foster families and focused on booster seats. Four of the workshops were conducted in Spanish.

One of MCHBG funded workshops was Safe Travel for All Children, a specialized two-day training for certified child passenger safety technicians on safe transportation for children and youth with special health care needs.

The Injury Prevention Program participated in several initiatives lead by the CT Department of Transportation that impact motor vehicle injuries and deaths among children including the CT Safe Routes to School and the state Pedestrian-Bicycle Advisory Committees.

The Injury Prevention Program provided technical assistance on motor vehicle injury related issues to Family Health Section programs, other units within DPH such as the Day Care Licensing Unit and community programs.

DPH continues to provide PHHS Block Grant funding to local health departments for motor vehicle injury prevention programs. Two local health department conducted programs last year.

The CT CODES (Crash Outcome Data Evaluation System) Project worked on linking motor vehicle crash and hospital/ED data. A CODES Advisory Board, including data owners and users, was formed to help ensure that CODES data is used to develop and support motor vehicle

injury prevention programs.

Comadrona, HCWC and RFTS provided referrals and linkages so that infants and children served are properly secured when riding in a motor vehicle. If necessary, child safety seats are provided to clients who could not otherwise afford them.

CHCs, as EPSDT providers, provided age appropriate risk assessments to children and/or caregivers, anticipatory guidance and injury prevention information related to motor vehicle safety.

SBHC professionals routinely offered motor vehicle safety information to students in the form of one-on-one meetings as well as group sessions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities				X
2. Provide linkages to motor vehicle injury prevention resources		X		
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children				X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements				X
6. Utilize injury-related data to guide planning for state and community based programs and policy development				X
7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program (IPP) is contracting with Safe Kids CT to conduct 18 child passenger safety workshops targeting families, healthcare, childcare and community service providers. Workshops will be held April-September 2008 with focus on booster seat education and a 4-day child passenger safety technician course which leads to national certification for participants.

IPP is collaborating with state and local partners including Safe Kids and the CT Dept. of Transportation on motor vehicle injury prevention issues. Initiatives include CT Safe Routes to School and the state Pedestrian-Bicycle Advisory Committees and the CT Traffic Records Coordinating Committee.

The CT CODES Project completed linkage of 3 years of motor vehicle crash and hospital/ED data. CODES data has been analyzed for child safety seats/seat belts and teen drivers. Results were incorporated into DPH testimony in support of stricter teen driving legislation that passed in 2008.

IPP published an injury data book, which includes 5 years of mortality and hospitalization data. Analysis of injury related emergency department data has also been completed this year. Both

publications include sections on motor vehicle injury.

Comadrona, HCWC, RFTS, CHCs and SBHCs provide guidance and resources on motor vehicle-related child and student passenger safety.

c. Plan for the Coming Year

The Injury Prevention Program will work closely with Family Health Section programs to integrate motor vehicle injury prevention into Title V and other children's programs throughout the Department including Day Care Licensing and Emergency Medical Services for Children. The Injury Program will continue to participate in the Virtual Children's Health Bureau to strengthen internal agency collaborations around childhood injury prevention.

The Injury Prevention Program will provide technical assistance to Family Health Section programs, contractors, and target populations on motor vehicle injury prevention issues. The Injury Program will continue collaboration with Title V programs, CT Safe Kids Coalition, CT Department of Transportation and other partners on child passenger safety and other transportation safety issues that impact children.

The Injury Prevention Program will use CODES and Injury Surveillance system data in the development and support of programs and policies that address the risk factors for motor vehicle injuries among children and adolescents.

DPH funded case management programs for women and children will work more closely with Injury Program staff to enhance activities to reduce the death rate for children age 14 years and under caused by motor vehicle crashes. DPH will provide injury prevention materials to all of its programs that serve the target population.

SBHCs will include motor vehicle safety as an integral focus of events and services. Community Health Centers, as EPSDT providers, will provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				36.8	39
Annual Indicator			36.8	38.8	
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	48	49	50	51	52

Notes - 2007

CY 2007 data are not available.

Notes - 2006

The prior/retired breastfeeding measure NPM 11 monitored breastfeeding rates at hospital discharge. As of June 2007, CDC's National Immunization Survey results present estimated breastfeeding rates according to the year of the child's birth to facilitate the evaluation of breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives.

Prior to June 2007, CDC presented this breastfeeding information by year of respondent interview as given in the current table.

CT's revised rates using the new methodology as of June 2007 are 40.8% for 2003 and 44.6% for 2004. Using this more recent data, annual performance objectives should be 45.0 for 2005, 46.0 for 2006 and 47.0 for 2007.

Annual performance objectives for 2008-2012 have been updated accordingly.

Websource: www.cdc.gov/breastfeeding/data/report_card2.htm

Notes - 2005

This year NPM 11 measures breastfeeding at 6 months. The prior/retired breastfeeding measure NPM 11 showed data for breastfeeding at hospital discharge. Source: 2004 CDC's N.I.S. has a confidence interval of +/-5.8%. Data is from CY2004 NIS survey sampling with numerator and denominator derived from projections to DPH birth data. Websource: www.cdc.gov/breastfeeding/data/NIS_data/data2004.htm. Ross Laboratories "Mother's Survey" reports 35.3 for 2004. This falls within the confidence interval for NIS data.

a. Last Year's Accomplishments

It will not be possible to indicate whether this measure was met or not this year due to the change in the data reporting methodology by CDC in June 2007. Next year we will be able to review these figures against the updated annual performance objectives. Connecticut has exceeded the HP 2010 target for breastfeeding initiation.

DPH provided materials to Title V case management programs for pregnant women (HCWC, Healthy Start, Comadrona, RFTS) and informed them of continuing education opportunities. DPH provided English/Spanish breastfeeding information sheets for the packets mailed to all new mothers by the Immunization Program. In celebration of World Breastfeeding Week in August, DPH again displayed a prominent banner outside of the State Office Building.

A number of activities were initiated to address the recommendations in the 2006 Connecticut Breastfeeding Initiative report which included engaging Black churches and other Black institutions by recruiting and training church leaders to the benefits of breastfeeding; exploring sources of reimbursement for breastfeeding classes; the use of public information and mass media to reach specific audiences; the training of health care professionals, and use of peer education models, particularly at sites serving the women least likely to breastfeed. A Black church leader who was willing to pilot breastfeeding classes at her church was identified, but funding was not available to implement this effort or to develop a media campaign targeted to the Black community. However, a local WIC Program agreed to send staff to a health fair at the church and to consider providing on-site services in the future. Also, activities around multicultural health disparities resulted in receipt of a \$75,000 grant from the CT Health Foundation to a non-profit organization that provides childbirth & lactation education & labor support to limited English-proficient Hispanic women. A request for the reimbursement of breastfeeding classes under the CT Medicaid Program (HUSKY A) is still pending.

DPH was actively involved with the CT Breastfeeding Coalition (CBC), participating in monthly meetings and serving on the Board of Directors. The DPH Breastfeeding Coordinator also served on the committee that planned the October 2007 CBC conference. While the training of health care professionals continued to be a key priority for the CBC, the strategic planning effort that was led by the DPH Breastfeeding Coordinator identified social marketing and continuing

education specifically directed to physicians as priorities for FY 2008.

The WIC Program continued to partially fund the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital. However, a proposal to replicate the program that was submitted at the request of the state legislature was not funded. The DPH Breastfeeding Coordinator chairs a statewide WIC Breastfeeding Committee that comprises WIC Breastfeeding Coordinators from each local WIC Program. The WIC Program maintains an inventory of electric breast pumps that are issued to eligible women who are returning to work or school.

The breastfeeding initiation rate among WIC infants in CT increased to 57.8%, and the 6-month duration rate to 24.6% based on data submitted to the Pediatric Nutrition Surveillance System in 2006. However, both rates are far below the HP 2010 targets.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings				X
2. Identify and track breastfeeding data sources to further build infrastructure				X
3. Promote provider and consumer education and awareness through training and education				X
4. Implement recommendations of provider survey and consultant analysis of disparities in breastfeeding rates in African American women as appropriate				X
5. Promote and support the WIC Breastfeeding Peer Counseling Program		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CBC's 10/07 conference attracted 200 attendees. In 1/08, the DPH Breastfeeding Coordinator and 3 CBC members attended the 2nd National Conference of State Breastfeeding Coalitions, leading a discussion on CBC's coalition building experience. CT was among 10 states selected to pilot The Business Case for Breastfeeding worksite initiative, and CBC received a \$10,000 grant from HRSA. The DPH Coordinator wrote CBC's Strategic Plan and participated in the June 4 training session.

A new consumer education flyer was developed in conjunction with CBC to promote breastfeeding duration and will be distributed to all new mothers. DPH funds were identified to support 2 BF teleconferences in collaboration with the CT Chapter of the American Academy of Pediatrics. They are scheduled for 7/1 and 11/6/08. The Title V programs and WIC continue to provide education, support and referrals to mothers to initiate & maintain breastfeeding. The DPH breastfeeding banner will be on display during World Breastfeeding Week.

The WIC Program funded the DPH Breastfeeding Coordinator position during FY 08 (this was previously co-funded with MCHBG funds). WIC continues to partially fund the Hartford-based Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program and funds have been identified to replicate the program at Yale-New Haven Hospital. In June 2008, WIC sent 25 more individuals to the Certified Lactation Counselor course, including one physician.

c. Plan for the Coming Year

All DPH perinatal health programs will provide or refer clients to breastfeeding support services as integrated in their case management activities. A wide array of breastfeeding promotion and support activities will be implemented by the WIC Program statewide.

DPH staff will work with the new case management programs for pregnant women to ensure the inclusion of the promotion of breastfeeding and providing resources to support breastfeeding mothers.

DPH will participate in monthly meetings of the CBC, as well as Board of Directors and conference committee meetings. World Breastfeeding Week and CT Breastfeeding Awareness Month activities will be planned and implemented. Consumer education materials will be distributed via the Immunization Program's hospital discharge packets and other appropriate vehicles. DPH will continue to participate in the implementation of The Business Case for Breastfeeding and collaborate with the CT Chapter AAP on physician education.

Additional resources will be sought to continue to implement the recommendations in the 2006 Connecticut Breastfeeding Initiative report, in an effort to address racial and ethnic disparities in breastfeeding rates and to improve access to breastfeeding information and support for all families.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	97	99.9	98.2	99	99.1
Annual Indicator	100.0	98.0	98.9	99.0	
Numerator	41852	41696	41696	41744	
Denominator	41868	42545	42142	42147	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	99.2	99.3	99.4	99.5	99.6

Notes - 2007

CY 2007 data are not available

Notes - 2006

Source: CTDPH, CY2006 Final, E.H.D.I. Program, Family Health Section

Notes - 2005

FFY2005 births and CT Early Hearing Detection and Intervention System. The newborn screening program started in 2000.

a. Last Year's Accomplishments

This measure was successfully met. CT has an internet-based reporting system for birth hospitals to report hearing, bloodspot and birth defect screening data to the DPH. The EHDI database is now able to link to the Electronic Vital Records System (EVRS), and generate reports that identify out of hospital births, as well as aggregate demographic data of the newborn population.

In January 2007, the EHDI program and University of CT released a web-based training for pediatric healthcare providers titled, "Newborn Screening in CT". The training provides an overview of CT's Newborn Screening (Hearing and Bloodspot) Programs and participants receive free CME and CEU credits for successful completion.

In January 2007, Newborn Screening staff presented at the annual Nurse Midwives Association meeting to reinforce the importance of timely newborn lab and hearing screenings. EHDI staff assisted a large home-birth practice to acquire donated hearing screening equipment from a local hospital and will begin collecting hearing screening data on this population once staff are trained.

The EHDI program has a proactive tracking and follow-up system in place to assure all babies are screened at birth, and those who do not pass receive timely diagnostic follow-up. The overall goals are to provide early hearing detection and intervention in an effort to minimize speech, language and other delays and to decrease the number of infants who are lost to follow-up. Bi-monthly reports are sent to hospitals to obtain missing screening results. Letters are sent to the primary care provider (PCP) of any child who did not pass the hearing screen and did not receive timely diagnostic audiological evaluation. Follow-up phone calls are made to the child's family and PCP in an effort to determine if audiological testing is scheduled and/or has been conducted. EHDI staff are in regular communication with diagnostic testing centers regarding children who were referred from newborn hearing screening. Enrollment into early intervention is confirmed for each newborn diagnosed with a hearing loss.

The CT EHDI Advisory Board was instrumental in encouraging the CT Birth to Three System (IDEA, Part C) to expand their eligibility requirements to include children with mild and /or unilateral hearing loss. The proposed budget option to expand eligibility was approved by our Governor, and took effect 7/1/07.

The DPH supported the CT Otolaryngology Association in a proposed legislative bill to increase hearing aid coverage for insured children, however, the bill did not pass.

EHDI staff attends the monthly CT EHDI Advisory Board meetings to discuss issues relevant to infant hearing, early identification and habilitation, and meets quarterly with the Commission on Deaf and Hearing Impaired Advisory Board.

The EHDI program conducted site visits to seven birth hospitals and provides ongoing technical assistance to screening and diagnostic staff as needed via telephone and e-mail.

In April, the EHDI coordinator conducted a presentation on risk factors for hearing loss at the "Together We Will" Conference, which is a multi-agency collaborative statewide conference. There were over 400 in attendance.

In May, the DPH sponsored a conference for audiologists titled, "Sound Foundations for Infants and Children with Hearing Loss." The agenda included education on the latest advances in audiology as well as best practice models for diagnostics, sedation, referrals to specialists, family education and support.

In July, the EHDI coordinator conducted a presentation on infant hearing and the EHDI program to graduate teacher of the deaf students at the University of Hartford.

The EHDI staff conducted a conference titled, "Maternal and Child Health Public Health

Initiatives," for hospital staff in September of 2007; continuing education credits were offered to participants. The conference incorporated presentations on various MCH topics including the EHDI process, genetic newborn screening procedures, the Birth Defects Registry process, lead exposure (pre and post natal concerns) the CT IDEA Part C Birth-To-Three System, child passenger safety and perinatal depression. It was attended by over 70 health care providers in the state.

An EHDI program annual report was dissemination to key stakeholders and was posted on the DPH's website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve state data tracking system				X
2. Improve follow-up on missed or abnormal screens				X
3. Improve follow-up on infants lost to diagnostic follow up				X
4. Improve tracking on follow up program for infants at risk for hearing loss			X	
5. Educate primary care providers on genetic factors associated with hearing loss				X
6. Distribute culturally sensitive educational materials to parents			X	
7. Assure linkage to a medical home		X		
8. Hire support staff to assist with tracking and follow-up				X
9.				
10.				

b. Current Activities

The EHDI staff conduct ongoing tracking, surveillance and follow-up to assure that infants are screened at birth, that those who do not pass the screening receive audiological follow by three months of age and that those diagnosed with a hearing loss are enrolled in early intervention by six months of age. Hospital screening referral rates are closely monitored and site visits are conducted for any facility with referral rates exceeding 4%.

The EHDI program provided funding to the one home birth practice in the state to obtain OAE screening equipment, and home births are now screened within one week of birth. As of 1/08, the midwife practice began reporting the hearing screen results through the Newborn Screening web-based reporting system, which enables DPH to accurately report the screening status of home births.

Technical assistance is provided to hospital staff and Diagnostic Audiology Centers through site visits, emails and telephone calls. Site visits are conducted to any hospital with nurse manager changes and/or if screening referral rates exceed 4%.

Pediatric healthcare providers are educated about "Newborn Screening in CT" through the free, web-based training that was developed by the EHDI staff and UConn Genetics. To date 207 providers have participated in the training.

c. Plan for the Coming Year

EHDI staff will increase the focus on educating hospital staff, pediatric healthcare providers and families on the importance of assessing and providing follow-up audiological testing to infants identified with risk factors for hearing loss.

The EHDI staff will work with the CT AAP Chapter Champion to standardize the hospital discharge summaries to include language that explains what a "failed" result from the hearing screen means.

The DPH will conduct a one-day educational conference for the Diagnostic Audiology Testing Center and other audiologists to discuss issues relevant to infant hearing loss, early hearing detection and intervention, reporting results to DPH, and other related topics.

The EHDI program will sponsor a one-day educational conference for hospital staff to increase their knowledge of newborn screening, infant hearing loss, risk indicators, late onset and progressive hearing loss, communicating results to families, the diagnostic referral, and tracking and follow-up.

Informational materials will be sent to obstetricians to increase their awareness about congenital hearing loss and the benefits of early hearing detection and intervention.

Educational materials will be developed for parents of infants identified with risk factors for hearing loss, who pass the newborn screening but require ongoing monitoring. The information will be shared with families and health care providers to increase awareness about monitoring for late onset or progressive hearing loss.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	4.5	4.4	4.4	8.4	7.6
Annual Indicator	4.7	4.5	8.5	7.7	6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	5.9	5.8	5.7	5.6	5.5

Notes - 2007

Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2006.

Annual performance objectives for 2008-2012 were updated based on the most recent data indicating a steady decrease.

Notes - 2006

Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2005.

Notes - 2005

This year's data source with target population has changed. Prior years reflected a 3 year average for the poverty population. This year's percent refers to the entire CT pediatric (<18) population. Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2004.

a. Last Year's Accomplishments

This measure was successfully met. In 2005, the data source was updated to use the US Bureau of the Census, Current Population Survey, Table HIA-5. A decreasing trend has been indicated since 2005 showing a 2.5% decrease in the percent of children without health insurance. Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, Regional Medical Home Support Centers and WIC screened families for insurance coverage, and provided support, information and linkages to health care insurance coverage for children. Right From the Start and Comadrona programs provided linkages to insurance coverage and continued for the first half of the year, after which funding was consolidated and sent out to competitive bid for case management for pregnant women and teens. It is anticipated that this new program will continue to screen families for insurance, and provide the same support, information, and linkages to health care insurance coverage for children.

The Perinatal State Health Plan identified as one of its goals the need to improve access to a continuum of health care services for underserved and/or unserved women of childbearing age. The development of this goal has implications for improved birth outcomes and will assist in identification of insurance for infants as well as their mothers.

Infoline provided MCH information and referral services including access to insurance, and conducted presentations and training to community based agencies and groups regarding the HUSKY program

SBHCs are considering a proposal to study uninsured elementary students to estimate the prevalence of the problem of lack of insurance, identify best practices to increase insurance enrollment, and develop recommendations regarding SBHC's practices to enroll more families in HUSKY.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, screening and referral to sources of health insurance		X		
2. Provide advocacy and liaison to assist families in obtaining health care coverage		X		
3. Provide education regarding resources to consumers and community-based providers				X
4. Support the state's information and referral services as a point of access for insurance coverage			X	
5. Provide follow-up and assistance with insurance application process		X		
6. Develop capacity with local organization as resources for outreach and enrollment				X
7. Provide education regarding resources to consumers and community-based providers				X
8.				
9.				
10.				

b. Current Activities

Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, Medical Homes (care coordinators) and WIC screen families for insurance, and provided support, information and linkages to health care insurance coverage for children. All MCH programs will continue to collect data on the number of uninsured children that are served.

Infoline continues to serve as the state's single-point-of-entry, toll-free (24 hours/day, 7 days/week) information and referral service for health care coverage. Infoline has a HUSKY line that is dedicated to providing information about the HUSKY program. Both infoline and the Department of Social Services' (administrator of the HUSKY program) websites provides families with information about the HUSKY program.

The care coordinators co-located in the CYSHCN medical homes provide families with information about insurance for their children. Care Coordinators will assist families with insurance/HUSKY applications, which are often burdensome and difficult to understand for families.

c. Plan for the Coming Year

A legislative mandate is being implemented that requires the State Department of Education to identify students who lack health insurance and provide information to their parents about the HUSKY plan. This new mandate coupled with the protocols in place at each of the DPH funded SBHC sites to reduce the number of uninsured enrollees will provide opportunities for increased collaboration between the school and the SBHC sites to expand HUSKY outreach and enrollment.

MCH Infoline continues to cite financial coverage for health care as a primary service request. Infoline will provide MCH information and referral services including access to insurance, and conduct presentations and training to community based agencies and groups regarding the HUSKY program

Three new contractors will provide case management services to pregnant women in teens in the cities of Waterbury, Hartford and New Haven who do not qualify for other existing programs. These new programs will screen families for insurance, provide support, information, and linkages to health care insurance coverage for children.

CYSHCN program will link children and families without insurance to the HUSKY program. Care Coordinators will assist with the completion of the HUSKY application as necessary. Care Coordinators will also assist families in resolving any insurance denials.

The MCH Advisory Committee will monitor access to health insurance for children (as noted in the State Perinatal Health Plan).

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				23.9	9.2
Annual Indicator			24.0	9.2	32.2
Numerator			7143	2709	7521
Denominator			29729	29481	23356
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	32.1	32	31.9	31.8	31.7

Notes - 2007

Source: CDC's Pediatric Nutrition Surveillance System (PedNSS) revealed that 16% of children enrolled in the WIC Program in 2007 were at risk of overweight (BMI \geq 85th and $<$ 95th percentile) and that 16.2% were overweight (BMI \geq 95th percentile). A total of 7,521 out of 23,356 children had a BMI at or above the 85th percentile, for a combined prevalence of 32.2%. Annual performance objectives for 2008-2012 have been adjusted based on the most recent data.

Notes - 2006

Source: CTDPH, WIC Program, SWIS monthly report on risk factors, Jan. 2007 (Children's BMI between 85 and 95%). This data is provisional because the WIC program was just beginning to calculate BMI electronically.

Notes - 2005

This measure changed, so this is the 1st year we're reporting this data. The percent reported is a BMI approximation from the January 2006 monthly SWIS report, CT WIC program.

a. Last Year's Accomplishments

This measure was not met using a comparison of CT data and national figures. The CT CY2007 annual indicator of 32.2% of children with a BMI at or above the 85th percentile is more than the national 2007 figure of 31.2% (reported in PedNSS).

The local WIC Programs in CT used the automated BMI calculation feature in the Statewide WIC Information System (SWIS) as a tool for assessing growth and teaching parents and care providers about their children's growth pattern. During 2007, the CT WIC Program kicked off the statewide implementation of a national initiative titled, Value Enhanced Nutrition Assessment. "VENA" is part of USDA's continuing effort to improve nutrition services in the WIC Program -- Revitalizing Quality Nutrition Services (RQNS). Its guiding principle is to, "Strengthen and re-direct WIC nutrition assessment from eligibility determination to individualizing nutrition education in order to maximize the impact of WIC nutrition services." CT activities included the establishment of a VENA core committee, with representation from all local agencies, and continuing education for local WIC staff. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants. In Hartford, women enrolled in the WIC Program and delivering at Hartford Hospital continued to have breastfeeding peer counselors available to them through the Hispanic Health Council/Hartford Hospital Breastfeeding: Heritage and Pride (BHP) Program. All local agencies provided breastfeeding education and support to participants, with on-site breastfeeding classes presented on-site at most local offices. There are 13 DPH Funded Community Health Center Corporations (CHC) located at over 100 sites in rural and urban areas across Connecticut that provide services to children ages 2 - 5 years old. Children under age 5 represent 6% of CT's population. Yet, this age group represents 12% of the patients who receive primary care services at CT CHCs. CHCs collect height and weight information on all well childcare visits and provide screenings for WIC eligibility. Culturally appropriate nutritional counseling is offered to families as needed.

Several state and community agencies (Department of Public Health, Education Children and Families and Connecticut Commission on Culture and Tourism) collaborated with the Department of Environmental Protection to launch the "No Child Left Inside" program, which is a major state initiative designed to reconnect youngsters with the outdoors, build the next generation of environmental stewards and showcase Connecticut's state parks and forests. The campaign is designed to help combat childhood obesity - which is a growing and significant threat to the health and life expectancy of our young people. Family friendly activities and park discounts are offered as part of the statewide campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Automate WIC database to generate BMI				X
2. Training of WIC providers in using BMI				X
3. Meet with CHCs re: BMI and nutritional services				X
4. Support the No Child Left Inside campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

VENA implementation by the CT WIC Program continues at a steady pace, including training for local WIC staff and the revision of forms and procedures. WIC funding was identified to replicate the Hartford-based Breastfeeding: Heritage and Pride breastfeeding peer counseling program in New Haven.

Staff will meet with the CHCs and determine the BMI information collected on children 2-5 years of age and extend to nutritional services provided to families.

DPH will partner with the Department of Environmental Protection on the expansion of the "No Child Left Inside" program. The intent of the program is to highlight the state parks and offer discounted or free admissions to encourage families to engage in physical activity. This year, a bike program is being added and will include providing transportation from the urban cities to the state parks, where families will be able to receive a "loaner" bike to encourage bike riding in the park.

Although not directly targeted towards children, the SisterTalk Hartford (STH) program is a weight loss and management program for African American women that is conducted in the faith based community. Since women are primarily responsible for making food choices and cooking for the family, it does indirectly impact the health and nutrition of all family members. STH has been implemented in 12 African American churches in Hartford and the evaluation conducted demonstrated that women were able to take and keep off weight.

c. Plan for the Coming Year

VENA implementation by the WIC Program will continue through FY 2009. The New Haven breastfeeding peer counseling program will get underway and efforts to fund the replication of this program in other cities will continue.

A fall summit is planned to promote the Sister Talk Hartford program to the greater Hartford area (surrounding towns). Funding is being sought to offset the expenses of the program in order to attract African American women who would not be able to afford a more traditional weight loss program. The STH project, is a joint initiative between the DPH, the University of Connecticut Translation Practice Into Policy (TRIPP) Center, and the Ethel Donoghue Foundation. To date, proposals have been submitted to several foundations and an award was granted from the Aetna Foundation.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				3	0.2
Annual Indicator			3.1	0.2	
Numerator				84	
Denominator				41461	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	0.2	0.1	0.1	0.1	0.1

Notes - 2007

CY 2007 data are not available.

Notes - 2006

Source: CY2006 final data, CTDPH, Vital Statistics. Similar to 2005 calculation, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column in last year's application was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CT2004 provisional. This measure changed with the new guidance, so prior year's data are irrelevant.

a. Last Year's Accomplishments

This measure stayed the same from CY2005 to CY2006. For CY2005, the numerator should have been 89 and denominator 41,086 with a resulting 0.2% - the same as CY 2006. Both calculations are based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. CY2005 column is locked and could not be changed. The annual performance objectives were adjusted accordingly to reflect the more recent data. It has been recognized that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

The CT Quitline counseled and referred CT residents about tobacco use cessation. Quitline promotion packets for health care providers were mailed to all community health centers, school based health centers, family planning sites and WIC clinics. These packets include CT Quitline information, fact sheets, Quitline referral prescription pads and a provider fax referral sheet. The provider can fax this referral sheet directly to the Quitline which contacts the patient directly.

The Tobacco Control program awarded two community grants to local agencies working with pregnant and postpartum women in addressing secondhand smoke and cessation. These programs are the American Lung Association of CT (ALA) in partnership with Yale-New Haven

Hospital's Woman Center and the City of Meriden Health Department. The Meriden Health Department has developed a support group for pregnant and post partum women from the WIC clinic who have quit smoking. ALA is conducting educational programs through the nurses to clients which address second hand smoke and promote quitting.

The Title V-supported programs Healthy Start, Right From the Start, Comadrona and Healthy Choices for Women and Children screened women for smoking during pregnancy, provided counseling for the need to stop, and referred clients to smoking cessation programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CTQuitline	X			
2. Educate health care professionals and providers in cessation intervention and treatment				X
3. Educate public about the effects of tobacco use and secondhand smoke			X	
4. Screen and refer women to smoking cessation programs		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Quitline is funded until 2008 and will continue providing cessation services. Conferences and workshops are scheduled to address cessation and the treatment of tobacco dependence.

The Title V-supported programs Healthy Start and Healthy Choices for Women and Children will screen and counsel women for smoking and refer clients to smoking cessation programs. New case management programs for pregnant women will include the promotion of smoking cessation. In addition to screening women upon entry, usually during the first trimester, programs will address the need to screen again during the 3rd trimester. Findings from the screenings will be compared to determine the number who entered and successfully completed a smoking cessation program. Plans will be developed to mail Quitline packets to relevant Title V programs.

DPH has been awarded funds to provide Nicotine Replacement Therapy to callers to the CT Quitline. This funding will be available until 2008.

DPH is partnering with the Department of Social Services to market smoking cessation referrals to their Medicaid participants and providers. The cessation programs will be offered at the community health centers in CT and will target pregnant women and women of childbearing age.

c. Plan for the Coming Year

The Title V supported programs Healthy Start and Healthy Choices for Women will continue to screen and counsel women for smoking. New case management programs for pregnant women will include the promotion of smoking cessation, including screening during the first and third trimesters, counseling, and referrals to smoking cessation programs.

FHS Epi staff will conduct the 2009 PRATS which will provide information about smoking habits before, during and after pregnancy. The analysis of this data will provide information about the scope of smoking cessation services that are needed for women during the perinatal period, and will provide leverage when advocating for additional funding.

Staff will partner with DSS on the implementation of smoking cessation programs at the CHCs. There is an independent evaluation that will be conducted and the analysis will be disseminated.

Staff will work to implement the recommendations from the "Addressing LBW Strategic Plan", which proposes to (1) support the Tobacco program efforts to implement evidence-based tobacco cessation programs during pregnancy, and (2) evaluate the effectiveness of tobacco cessation program in a group healthcare setting (similar to Centering Pregnancy Model).

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.6	5.6	2.5	2.5	3.8
Annual Indicator	2.6	2.9	4.0	6.4	
Numerator	6	7	10	16	
Denominator	234895	241182	247415	250071	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	6.4	6.3	6.2	6.1	6

Notes - 2007

CY2007 data is not available.

Notes - 2006

Source: CT Dept of Public Health, Vital Statistics final CY2006 data

Note: The Annual Performance Objective for 2006 and 2007 can not be changed based on the most recent data because the fields are locked. The Annual Performance Objective for 2008 forward were changed to reflect the more recent data.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CY2005 is the most recent data available in June 2007. CY2006 data are not expected to be available until a year from now. Denominator represents DPH 2005 population estimates (HISR, Backus & Mueller).

Note: The 2006 objective was not able to be changed in light of the most recent data. It is locked by the form at 2.5 when we would have liked to change it to read 3.9.

a. Last Year's Accomplishments

In 2006, CT did not meet this measure with an increase in the number of suicide deaths from 10 in CY2005 to 16 in CY2006, resulting in a rate that is more than double the annual performance objective in 2006. The small numbers that are reported for this measure make the stability of the

rate susceptible to random fluctuation. The annual performance objectives were adjusted based on this CY2006 figure; however both the higher percents in CY2005 and CY2006 may be outliers, and if so the annual performance objective adjustments should not have been made.

CHCs provided mental health services through assessment, direct care and/or referrals. They assured these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. The Community Health Centers (CHC) are working closely with the Child Guidance Centers across CT, and some of the Child Guidance Centers are operated by CHCs.

SBHCs provided anticipatory guidance and mental health risk assessments at all locations. Other mental health services included crisis intervention, individual, family, and group counseling and referral and follow-up for specialty care. All SBHCs offered services directed at high-risk populations, such as youth with suicidal thoughts/attempts.

Through the use of a specially designed Mid-year report, SBHC sites reported on the following mental health related issues: successes in service delivery, trends, gaps/barriers, and potential solutions.

Continuing education for SBHC mental health clinicians was provided this year. Thirty-eight SBHC mental health clinicians registered to attend one of four child and adolescent focused UConn Health Center sponsored Master Therapist Workshops including one entitled "Angry Adolescents: Struggles and Strategies."

Healthy Choices for Women and Children provided comprehensive assessment of clients, including the need for mental health services. Referrals are initiated as necessary. This program identified and referred clients who are at risk for suicide to appropriate resources.

Right From The Start provided comprehensive assessment of clients, including the need for mental health services with referral as necessary.

There were also non-Title V funded activities. The Injury Prevention Program provided guidance related to suicide prevention and other intentional injury issues to other DPH program staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention training to students				X
2. Provide suicide prevention training to providers and other adults				X
3. Provide technical assistance and guidance for MCH programs				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially SBHCs		X		
5. Provide mental health services through assessment, direct care and/or referrals in SBHCs, CHCs and other MCH programs	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The program activities presented in the Current Activities section will be continued into FY07 with the continued goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among adolescents.

School Based Health Centers provide anticipatory guidance, risk assessments and mental health therapy at all locations. Staff will work with SBHCs to enhance data collection tools related to mental health service delivery at SBHCs.

The new case management program for pregnant women and teens include screening for perinatal depression. This program covering the towns of Hartford, New Haven and Waterbury is being implemented in 2008 after a competitive bid process. Perinatal depression screening will be implemented in the state Healthy Start and the new programs that provide case management services for pregnant women (and teens).

The activities of the new HRSA mental health services for adolescents grant are being conducted. Staff are working with the consultant, Eastern AHEC and a grant advisory committee, to develop a train-the-trainers curriculum. The curriculum is currently in draft form and is being reviewed by the grant advisory committee.

c. Plan for the Coming Year

DPH will screen for perinatal depression through the new case management program for pregnant women and teens and through other case management programs such as Healthy Start and HCWC.

Safety Net Providers, such as SBHCs and CHCs will provide mental health services through assessment, direct care, and/or referrals. Most CHCs and SBHCs provide onsite mental health services, however we will monitor the increasing lack of mental health services, particularly for children.

The curriculum for the train the trainer program for non-mental health state employees will be implemented (HRSA funded). The purpose of this program is to build capacity among non-mental health state employees' understanding of normal middle childhood and adolescent development as well as how to distinguish between risk and protective factors, promote resilience (work with strengths and assets) and to identify appropriate responses to challenging behavior. Additionally continue to offer training opportunities for SBHC mental health clinicians to attend Master Therapist Workshops offered through UConn Health Center on various topics dealing with adolescent behavior and mental health issues.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	87.5	87.5	87.5	87.3	87.4
Annual Indicator	87.4	87.1	87.1	86.3	
Numerator	557	575	580	591	
Denominator	637	660	666	685	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	87.5	87.6	87.6	87.7	87.8

Notes - 2007

CY 2007 data are not available.

Notes - 2006

Source: CY2006 final data, CTDPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

Notes - 2005

Source: CY2005 final data, CTDPH, Vital Statistics. The facilities included in this measure are eleven hospitals with self-reported NICU's as reported to the state Office of Health Care Access. CT does not currently have ACOG "high risk" level certification/recognition system in place for its hospitals.

a. Last Year's Accomplishments

This objective was not met and there appears to be a steady decline in the percentage. Vital Statistics staff did indicate that the 1.1% decline from 2003-2008 is not statistically significant (L. Mueller, HCQSAR). CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York border. There are 11 "self-defined" Level III Neonatal Intensive Care Units in CT.

The State Perinatal Health Advisory Committee, which is now part of the MCH Advisory Committee met as scheduled (quarterly). The MCH Advisory Committee has representation from the State Departments of Public Health, Social Services, Mental Health and Addiction Services, New Haven Federal Healthy Start, Permanent Commission on the Status of Women, Planned Parenthood of CT, CT Chapter of the March of Dimes, AAP, and others. One of the recommendations in the plan identifies the need to reduce pregnancy and birth related risk factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high risk antepartum, intrapartum and postpartum care.

The Title V-funded programs Comadrona, Healthy Start, Right From the Start, and Healthy Choices for Women and Children provided outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers. Through a case management approach, women identified as at-risk were referred for appropriate evaluation. Programs, such as Comadrona, provided focused outreach, risk assessment and case management services to pregnant women who, by virtue of cultural and linguistic barriers, have difficulty obtaining needed care. These women were referred to culturally appropriate health and related social services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high-risk pregnant teens				
2. Provide intensive case management and supports to promote positive pregnancy outcomes		X		
3. Provide culturally competent and linguistically appropriate care to high-risk populations	X			
4. Collaborate with tertiary care centers that provide specialized				X

delivery and neonatal care				
5. Collaborate with the members of the State Perinatal Health Advisory Committee to implement the plans goals and objectives				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Healthy Start, Family Planning, Healthy Choices for Women and Children, and Community Health Centers assess and refer high-risk pregnant women to facilities for high-risk deliveries and neonates. Funds from the Right from the Start and Comadrona programs were blended and a Request for Proposals submitted to create a new program to promote case management for pregnant women and teens; this program will continue to provide outreach, screening, case management and referral for high-risk pregnant women to specialists and tertiary care centers.

The State Perinatal Health Advisory Committee, which is now part of the Infoline MCH Advisory Committee continues to meet. The MCH Advisory Committee is the vehicle for discussing and implementing the recommendations from the State Perinatal Plan, and specifically reviewing the activities and resources needed to better address this NPM.

This downward trend is somewhat alarming; however, it is consistent with the recommendations identified in the recently developed Strategic Plan for Addressing Low Birth Weight in CT, which identified the need to coordinate with medical providers to ensure that high-risk pregnancies deliver in tertiary care hospitals. It was also identified in the State Perinatal Plan.

c. Plan for the Coming Year

Healthy Start, Family Planning, Healthy Choices for Women and Children, the new case management program for pregnant women, and Community Health Centers will provide outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers. Follow-up will be conducted on pregnant women referred for high-risk OB services.

The MCH Advisory Committee will meet and identify resources, develop and implement strategies to better address this objective. The Title V Director will ensure that this is on a meeting agenda and will present the data and solicit input from the group. A strategy on how best to reach OB providers will be developed in concert with the MCH Advisory Committee. The CT Chapter of ACOG will be contacted to ensure their participation in this discussion.

FHS Epidemiologist will conduct a more in-depth review of the birth (and fetal and infant death) data, to better assess where (which facilities) the VLBW are occurring, and look for any trends or other indicators that might better explain this gradual decrease.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	88.8	88.9	88.9	87.8	87
Annual Indicator	88.8	87.2	86.7	85.8	
Numerator	37454	36090	35654	35303	
Denominator	42176	41392	41103	41161	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	87.3	87.6	87.9	88.2	88.5

Notes - 2007

CY2007 data is not available

Notes - 2006

Source: CY2006 final

The objective field here is locked and not able to be changed as we would like to 87.0 i.e. a more reasonable projection based on a two-year downward trend.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CY2005 Final

The 2006 Objective field is locked by the form and not subject to change. We would have liked to change this to a more realistic projection based on two years' downward trend i.e. 87.0 rather than 87.8

a. Last Year's Accomplishments

CT did not meet this measure in 2006 with a lower rate (85.8) than the annual performance objective of 87.8. The steady decreasing trend is a concern. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience which may actually be unwise. We also did not change the annual performance objectives for the future as further analyses may indicate the factors that are contributing to this decline that could lead to programmatic activity changes to address this issue.

Comadrona, Healthy Start, Healthy Choices for Women and Children, Right From The Start, Family Planning, School Based Health Centers, Community Health Centers and WIC identified and referred women to prenatal care, provided advocacy and a culturally sensitive approach in promoting the benefits of early and continuous prenatal care.

Fetal and Infant Mortality Review (FIMR) was implemented in five communities in CT. The FIMR process uses a confidential record abstraction and maternal interviews to identify mortality related issues including late entry into prenatal care. Although it was anticipated that the five FIMR contracts would be phased out in June 30, 2007, the legislature continued to fund these FIMR sites for the same activities. Thus, the FIMR programs and the Fetal Infant Mortality Surveillance will occur in conjunction with one another.

Starting in July 2006, the FIMR Program began a transition to statewide mortality surveillance through an MOA with UCONN. Efforts began to collect fetal and infant data statewide, including data from urban areas (Bridgeport, Waterbury, etc.) that were not part of the previous FIMR activities.

A public awareness campaign regarding infant mortality, particularly among African Americans and encouraging early entry into prenatal care, was conducted using radio, television, and minority newspaper advertising in the Greater Hartford and New Haven areas. This is the second consecutive year an Infant Mortality campaign has been implemented.

The Perinatal State Health Plan goal to improve access to a continuum of health care services for underserved and/or unserved women of childbearing age is currently being evaluated by the State Perinatal Advisory Committee. Initial plans are to assess the extent of services provided under current programs. The work of the State Perinatal Advisory Committee was merged with the recently reconvened MCH Infoline Advisory Group.

The newly developed state added performance measure # 6 will allow CT to more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment that impacts this measure.

DPH is collaborating with the John Snow Institute (JSI) to promote several workshops to community providers regarding best practices in teen pregnancy, including recommended methods to implement and evaluate teen pregnancy programs.

A Health Disparities workgroup was convened to address the issue of health disparities. As a result, a Strategic Plan was developed to address low birth weight that often results from late or inadequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users)		X		
4. Provide support, information and advocacy to pregnant teens		X		
5. Continue to analyze and disseminate PRATS Survey data			X	X
6. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers	X			
7. Develop a statewide fetal and infant mortality surveillance program			X	X
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
9. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
10.				

b. Current Activities

WIC, Healthy Start, Family Planning, School Based Health Centers, Healthy Choices for Women and Children and Community Health Centers continue their efforts as described in the Current Activities section by encouraging early entrance into prenatal care. Funds from the Right from the Start and Comadrona programs were blended and a Request for Proposal submitted to create a new program to promote case management for pregnant women and teens; this program provides outreach to identify and refer women for early entry into prenatal care. The Fetal Infant Mortality Surveillance program was implemented on a statewide basis and will provide

information about entry into prenatal care and provide recommendations for improving entry rates.

Data obtained under the newly developed state added performance measure #6 will allow CT to more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment which impacts this measure.

The infant mortality campaign that was previously developed is being redesigned and will consist of television advertisements. The campaign will include messages about the importance of early and regular prenatal care. The campaign is focused on African American women and will be targeted in the Hartford and New Haven communities.

c. Plan for the Coming Year

Title V Programs Healthy Start, Healthy Choices for Women and Children, and the new case management program for pregnant women will provide outreach and identification of pregnant women to promote early entry into prenatal care. Programs not fully funded by the MCH Block Grant including Family Planning, School-Based Health Centers, Fetal and Infant Mortality Review and Surveillance, Community Health Centers and WIC, will also promote early entry into prenatal care.

Epidemiology Unit staff will continue preparations for Round 3 of the CT PRATS survey. This work will include refining the sampling plan based upon analyses of respondents versus non-respondents from the previous 2 surveys; identifying an appropriate birth cohort and drawing the sample; finalizing survey content; and releasing an RFP to identify a contractor to administer the survey. Data from Round 3 will be used to identify and further investigate important factors related to seeking and accessing early prenatal care.

With the launch of the Charter Oak Plan, more adults (especially the working, but uninsured population) will have access to health insurance. This may impact this measure in a positive direction.

We will work to implement the following recommendations from the LBW Strategic Plan: (1) facilitate case management services for first time pregnancies; (2) coordinate with medical providers to ensure evidence-based treatment for pregnancies at risk of preterm-birth; (3) Advertise the use of Infoline 2-1-1 to assure referrals for early and regular prenatal care; (4) document that all DPH funded initiatives address language, culture, diversity and health literacy; and, (5) continue to provide technical assistance to the Hartford Health Department in their pursuit of a federally-funded Healthy Start Program.

D. State Performance Measures

State Performance Measure 1: *Cumulative number of datasets incorporated into integrated warehouse (called HIP-KIDS).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				3	2
Annual Indicator			2	2	2
Numerator			2	2	2
Denominator	7	7	7	7	7
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	3	4	5	6	7

Notes - 2007

The number of databases linked as part of HIP-Kids remained at 2. Database linkages were put on hold due to the shift of DPH's focus on the migration of databases to a standardized network platform that met IT state-of-the-art requirements.

Adjustments were made to the 2008-2012 annual performance objectives due to this change in plans.

Notes - 2006

Data is supplied by DPH staff working on the HIP-KIDS project. Two of the seven databases were incorporated into the data warehouse in 2005. There were no new additions in 2006.

Notes - 2005

Data is supplied by DPH staff working on the HIP-KIDS project. Two of the seven databases were incorporated into the data warehouse in 2005.

a. Last Year's Accomplishments

This measure was not met. The number of linked databases remains at 2 because of a DPH focus to migrate databases to a state-of-the-art standardized IT network platform. Work toward creation of HIP-Kids continued. Funding from the EPHT program was obtained and these funds were used to implement a statewide network that includes comprehensive noninfectious disease data. The first significant step of this process was to begin migration of databases to a single platform. Also, enhancements were made to the CHP to allow front-end reporting of data.

In collaboration with the Office of Health Care Quality, Statistics, Analysis and Reporting, work toward the implementation of CHIERS (Connecticut Health Information Electronic Reporting System) continued. A prototype of CHIERS was nearly complete. This would allow access to aggregated data on health-related topics. The prototype was planned to contain information on births, newborn hearing screening results, childhood lead screening results, and resident population. These data were made available in details that include age, race, ethnicity, sex, town of residence, etc. The tool was modeled after MICA, which was created and maintained by the Missouri Department of Public Health. Development of CHIERS was made possible by a training opportunity offered by the Missouri DPH, and in collaboration with staff there.

FHS staff participated on the Virtual Child Health Bureau Data Committee.

The total number of linked databases remained at 2, although planned infrastructure improvements to use a single platform should allow easier linkages in the future.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepare for the migration of the CHP database to the PHIN platform by documenting the business needs of the NSS.				X
2. Pursue funding for HIP-Kids project				X
3. Continue to participate on the Department-wide Data Committee				X
4. The electronic reporting system, CHIERS, was updated.				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The migration process to move databases to a single platform became a major focus within DPH with the goal of prioritizing which databases should be migrated first to the Public Health Information Network (PHIN) platform. The Newborn Screening's CHP database was included in the priority list of databases to be migrated. This precipitated the need for FHS staff to identify the business needs of the Newborn Screening System. During the summer of 2007, FHS worked with Scientific Technologies Corporation Inc. to complete a detailed documentation of the business needs of the entire Newborn Screening System (NSS) including the CHP in preparation for its migration to the PHIN platform. This took priority over completing the linkage of the death records.

The electronic reporting system, CHIERS, was updated to include the 2006 birth data; added new confidence interval option (from MICA system) for percentages to the CT CHIERS version; and the web page was modified to meet the CT DoIT standard.

c. Plan for the Coming Year

Using funds provided by the Environmental Public Health Tracking program, and pending additional funds, the CHP will be migrated to a platform that is compatible with database integration. This significant step should allow easy integration of other health-related databases that are also maintained on the platform. Once the NSS is migrated to the PHIN platform, advancements for the data warehouse will be restarted. Completion of the death record linkage to the CHP database and the birth records is planned. Identification of a fourth database for inclusion in the HIP-Kids data warehouse will be completed if time permits. The results of an assessment, given more recent information, will help determine which database should be chosen for linkage.

State Performance Measure 2: *Cumulative number of formal agreements, in the format of Memoranda of Agreements (MOA's) and collaborative agreements, that serve the needs of the three MCH populations.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				13	17
Annual Indicator			12	16	20
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	21	22	23	24	25

Notes - 2007

CY2007 data are from a survey of FHS programs.

Adjustments were made to the 2008-2012 annual performance measures based on this most recent data.

Notes - 2006

Data is from a survey of DPH programs including the CGMS database.

Notes - 2005

Data is from a survey of DPH programs including the CGMS database.

a. Last Year's Accomplishments

This measure was successfully met with a total of 20 MOU's or agreements that have occurred. DPH staff met with and executed new MOAs with UConn for the statewide Fetal and Infant Mortality Program, CYSHCN, and Genetics Services. A separate existing MOA with UCONN for the regional FIMR was continued. The existing Abstinence Only MOA was amended to include development, piloting and analyzing of a curriculum for at risk youth. In addition to the partnership with UConn, this activity was in collaboration with the State Department of Children and Families.

The Title V Director met with the Program Director of the New Haven Federal Healthy Start Program and renewed the Letter of Agreement to establish new priorities/goals for FY 07.

Staff met with DSS CT Healthy Start Program Manager to negotiate new terms for the FY 07 MOA to provide case management services for Medicaid eligible pregnant women. The DPH continued the existing MOA with DSS for the data sharing between departments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify collaborating partners at the state and local level				X
2. Inventory existing collaborations				X
3. Identify gaps in existing collaborations and opportunities for new partnerships				X
4. Monitor the effectiveness of collaborations and interventions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Population Group- Women: FHS Staff are working with the Department of Corrections (DOC) staff to develop an MOA to implement a gender responsive curriculum for both DOC staff and inmates at York Correctional Institute (CT's only female prison).

Population Group - Children/Adolescents: An MOA with Area Health Education Center (AHEC) was executed to develop a train-the-trainer mental health curriculum to provide training to non-mental health professionals when they serve children/adolescents with mental health issues.

Population Group - CYSHCN: An MOA with the Children's Trust Fund was executed for 1/1/07 to 6/30/08 to complete care coordination services for CYSHCN for the North Central and Eastern regions after the termination of contracts with LEARN and Charter Oak Health Center. The MOA will continue to provide support for the transition of services to new care coordinators who will be identified in the RFP process effective 7/1/07.

Population Group - Pregnant Women/Infants: An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant mortality to understand what motivates and mobilizes communities to take action to prevent fetal and infant deaths. This statewide effort will identify the areas of

greatest need and involve community collaborations, case ascertainment utilizing vital statistics and other data sources, record review, and possibly maternal interviews.

c. Plan for the Coming Year

Population Group -Women: The MOA between DPH and the Department of Corrections (DOC) will conduct gender responsive curriculum for staff and inmates at York Correctional Institute (CT's only female prison).

The DPH will work with the Hartford Health Department to complete the Action Plan for addressing preconception care in the City. A summit for health care providers is being planned for the fall of 2008 and will give providers the opportunity to provide input into the plan, as well as help prioritize the recommendations that are included in the plan. Work has already begun on some of the recommendations and although the grant period has ended, will work with HHD to sustain the activities.

Population Group- infants: DPH will work with UConn on the statewide surveillance for fetal and infant mortality including partnering with the cities of Bridgeport and Waterbury, two 2 communities with known high rates of fetal and infant deaths, to identify trends around adverse birth outcomes that can be utilized to create strategies for comprehensive statewide fetal and infant mortality prevention and intervention.

Population Group - Children/Adolescents: An MOA with multiple State agencies was submitted as part of the SAMHSA application for Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health (Project LAUNCH). The purpose of Project LAUNCH is to promote the wellness of young children birth to 8 years of age. Project LAUNCH will work towards coordinating population-based programs and also promotes protective factors that support resilience and healthy development, which can protect individuals from later social, emotional, physical and behavioral problems.

A MOA was executed with The CT State Board of Education (SBE) on July 1, 2008, to establish a collaborative partnership between SBE and DPH for the purposes of supporting local school districts and communities to improve the health and well-being of CT children and youth. This five-year agreement, funded by the CDC, supports 1 FTE at DPH. Once hired, this person shall serve as the DPH infrastructure coordinator for the Coordinated School Health Program.

Misc: An MOA with UConn's School of Nursing for PCO activities is planned. There are preliminary plans to coordinate two projects with the UConn School of Nursing.

One program will target high school students from urban high schools. The participants would spend a weekend at a hotel and conference hall and participate in a variety of activities including; dinner concerning health careers, shadowing a variety of health care providers including nurse, physicians, pharmacists, physical therapists, and/or dentists, attending a UConn athletic event as well brunch with a speaker regarding health careers.

The second program will target Boy Scouts and Girl Scouts, who will attend an after school program and participate in activities and listen to a speaker on nursing and health careers.

State Performance Measure 3: *Percent of 9-12 graders who reported being in a fight within the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				32.7	32.6
Annual Indicator			32.7	32.7	31.4
Numerator			715	715	630
Denominator			2185	2185	2007
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	32.6	32.5	32.5	32.4	32.3

Notes - 2007

This is weighted 2007 CT High School Survey (formerly called YRBS) data.

Notes - 2006

This is weighted 2005 CSHS(formerly called YRBS) data. The survey is conducted every other year, so new data is not available this year, but anticipated for the following year's MCHBG reporting.

Notes - 2005

This is the weighted percent, with adjusted numerator from the unweighted frequencies of CT School Health Survey 2005. This survey is conducted every other year in conjunction with CDC's YRBS national surveys.

a. Last Year's Accomplishments

This measure was successfully met with the decrease in the percent of high school students reporting that they have been in a fight in the past 12 months according to the recent 2007 CT School Health Survey (31.4% in CY2007 - a decrease from the 32.7% in 2005).

SBHCs statewide provided individual, family and group counseling to enrolled students and their families. Health education, promotion and risk reduction activities related to violence prevention were available to all students.

SBHC sites in the Bridgeport area implemented nationally recognized programs that include Positive Behavior Interventions and Supports (PBIS), a program geared toward preventing and responding to classroom discipline problems and Reconnecting Youth (RY), an indicated school based program for adolescents at risk for school dropout. Plans are being considered to continue implementation of Girl's Circle, a program for preventing girl violence.

SBHC sites in high schools statewide offered groups on topics including but not limited to anger management, conflict resolution, social skills, friendship, healthy relationships and life skills to prevent/reduce school violence including fights.

SBHC orientations, newcomers groups and other activities were also implemented to support youth during times of known vulnerability including middle to high school transition, transfer from other schools and immigration from other countries when there is increased likelihood for engaging in high risk behavior including fighting.

Health education/promotion/prevention activities included formal and informal presentations on topics including but not limited to: stress management, communication skills and self-esteem. Students participated in Violence Prevention Week activities and other related observances.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Trends related to the number of students who reported being in a physical fight in the past year will be monitored with the completion of the 2006 CT School Health Survey			X	
2. Creation of opportunities for teen employment and workforce skill development				X
3. Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills				X
4. Increase the number of schools that have peermediation/conflict resolution and social development programs				X
5. Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents				X
6. Support efforts to reduce availability of weapons				X
7. Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds				X
8. Reduce demand for drugs through substance abuseprevention and treatment strategies				X
9. Support efforts at the community level				X
10.				

b. Current Activities

Continuing education for SBHC mental health clinicians was provided this year. 38 SBHC mental health clinicians registered to attend one of four child and adolescent focused UConn Health Center sponsored Master Therapist Workshops including one entitled "Angry Adolescents: Struggles and Strategies".

SBHC groups focus on anger management, conflict resolution, social skills, friendship, healthy relationships and life skills to prevent/reduce school violence including fights. Several sites have targeted students in detention to provide them with education and insight into their behaviors.

SBHC sites in the Bridgeport continue to implement nationally recognized programs including Positive Behavior Interventions and Supports, a program geared toward preventing and responding to classroom discipline problems and Reconnecting Youth, a school based program for adolescents at risk for school dropout.

Through RFP process open to existing SBHC contractors, 7 SBHC programs statewide were awarded additional dollars to expand services to increase hours of operation, extend SBHC services into the summer months and offer SBHC services to evening high school students attending one community. This increased capacity of SBHCs to offer clinical mental health services will assist in reducing the number engaged in fighting and other violent behavior.

c. Plan for the Coming Year

SBHCs statewide will provide individual, family and group counseling to enrolled students and their families and conduct health education, promotion and risk reduction activities related to violence prevention that are available to the entire school population.

The state legislature has allocated funds in the 2008 state budget for specific SBHC sites to add/enhance mental health services including a very large high school located in eastern CT.

The curriculum for the train the trainer program for non-mental health state employees will be implemented (HRSA funded). The purpose of this program is to build capacity among non-mental health state employees' understanding of normal middle childhood and adolescent development as well as how to distinguish between risk and protective factors, promote resilience (work with strengths and assets) and to identify appropriate responses to challenging behavior. Additionally continue to offer training opportunities for SBHC mental health clinicians to attend Master Therapist Workshops offered through UConn Health Center on various topics dealing with adolescent behavior and mental health issues.

State Performance Measure 4: *Percent increase in the number of adolescents 10-20 years old who receive services in school based health centers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				4.2	15
Annual Indicator			3.1	10.2	15.6
Numerator			597	1986	3039
Denominator			19439	19439	19439
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	20	25	30	35	40

Notes - 2007

Source: 2006-7 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2006-7 there were 22,478 students seen. These 3039 additional students seen represent a 15.6% increase over the base year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

Notes - 2006

Source: 2005-6 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2005-6 there were 21,425 students seen. These 1986 additional students seen represent a 10.2% increase over the base year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

Notes - 2005

Baseline denominator is 2003-2004 number of students (19,439) receiving SBHC services. 2004-5 there were 20,046 students seen. These 597 additional students seen represent a 3.1% increase over the prior year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

a. Last Year's Accomplishments

This objective was successfully met by CT as the percent increase in the number of adolescents 10-20 years old who received services in school based health centers was 15.6% exceeding the projected 15% in the annual performance objective.

The Connecticut legislature appropriated an additional state funds added to SBHC contracts for staff cost of living adjustments and to maintain current hours of operation and service levels.

The CT State Legislature allocated \$1,030,000 in funding to implement expanded school health programs that include mental health and dental services to eight elementary schools in one new community, increasing the number of access points into care for students with limited resources and/or no insurance.

DPH staff participated in activities related to the SAMSHA Mental Health Transformation Grant as co-convenor of the Early Mental Health Prevention, Screening, Assessment and Referral to Services are Common Practice Workgroup which focused on developing and implementing strategies to increase access to mental health services for adolescents and other populations across the lifespan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers	X			
3. Provide outreach to targeted populations (i.e. pregnant and substance users)		X		
4. Provide support, information and advocacy to pregnant teens	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers	X			
6. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
8.				
9.				
10.				

b. Current Activities

Including a 3.5% COLA, the CT legislature allocated \$2.5 million in each FY 08 and FY 09 to enhance school based health services. Specific schools were identified to receive additional funds for medical/mental health services and support six new SBHCs statewide.

The remaining \$1.47 million in FY 08 and FY 09 was to be used to expand medical, mental health and dental services and mental health services at existing DPH funded SBHC sites located in priority school districts or medically underserved areas or serve medically underserved populations. Funds were dispersed through an RFP process to be used for variety of activities including but not limited to: expanding staffing and staff hours, providing SBHC services over the summer months; adding dental services and creating a SBHC program for evening students attending high school.

\$2 million in State bond funds for SBHCs for the purchase of equipment, renovations, improvements and expansion of facilities, including acquisition of land or buildings were also made available through RFP. Recipient requests included but were not limited to: the purchase of dental and other equipment and structural renovations.

A series of regional data training sessions were provided to SBHC contractors to enhance their

ability to provide quality data.

DPH remains involved with activities related to Connecticut's Mental Health transformation grant, managed by the Department of Mental Health and Addiction Services.

c. Plan for the Coming Year

Plans for the coming year will include full implementation of SBHC service expansions outlined in the RFPs of award recipients and newly established SBHC sites, monitoring the impact of expanded services and new sites on types of services provided, numbers of students served and other indicators of increased capacity and access.

SBHC outreach activities at the state and community level will include disseminating the SBHC brochure, updating the DPH website, participating in health fairs, attending conferences, increasing new collaborations with other state agency staff and community based providers around matters related to adolescents and school based health centers.

Efforts to ensure the quality of the data provided by the SBHC contractors will continue as will the availability of the support network.

Involvement with activities related to the Mental Health Transformation grant, Adolescent Health Plan and Ad Hoc Committee will be conducted.

SBHC staff will be represented on the CSHP Advisory Group to assure the integration of SBHC services into the coordinated school health model. The Ad Hoc Committee will design and develop initiatives to enhance student access to care in SBHCs.

State Performance Measure 5: *Percent of schools that have used a program to reduce obesity through physical exercise and nutrition education programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				6.5	7
Annual Indicator				6.5	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	8	8.5	9	9.5

Notes - 2007

CY 2007 data are not available.

Notes - 2006

State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

Notes - 2005

State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

a. Last Year's Accomplishments

This measure was not met as it did not have any updated data. State Dept of Education (SDE) did not complete the annual School Nutrition and Physical Activity Practices (SNPAP) survey due to other time commitments and a time-consuming review of district school wellness policies.

Family Health Section staff partnered with SDE to follow the completion of the School Nutrition and Physical Activity Practices Survey that was first conducted in the Spring 2006. Conducted in partnership with the Rudd Center for Obesity at Yale University, the results of the second annual survey were again used to develop the State Performance Measure, and to monitor implementation of school policies that promote healthy lifestyles and barriers to implementation. Data are not yet available to report on this objective.

On May 31, 2007, the Department of Education hosted a conference called "Measuring Success: Evaluating School Wellness Policies." This conference helped school teams learn strategies for evaluating school wellness policies.

The Nutrition, Physical Activity and Obesity Prevention Program (NPAOP) established the Connecticut Interdisciplinary Health Policy Advisory Team (CIHPAT), consisting of members from the Governor's Office, universities across the state (University of Connecticut, Eastern Connecticut State University, Yale, etc.), and key state agencies. The CIHPAT structured itself into four subcommittees that worked in tandem to successfully accomplish the following responsibilities: set criteria for the selection of health indicators and determination of data collection methodology; develop and pilot testing of a health risk assessment; design and implementation of a multi-level marketing and public relations strategy; and the development of a public policy agenda. A Protective Health Assessment (PHA) was designed and a web-based application constructed. The goal of the PHA is to contribute to improving the health, fitness and quality of life of an estimated 98,000 Connecticut state employees and retirees, through encouraging the prevention and early detection and treatment of chronic disease and related risk factors. The purpose of this online, interactive instrument is educational in nature, and is aimed at helping state employees and retirees assume increased responsibility for improving their own health behaviors and risk profile, based on current national objectives, guidelines and recommendations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support allocation of \$500,000 state funds to develop fitness programs and nutrition programs for overweight children				X
2. Promote partnership with newly created Obesity Program within DPH				X
3. Promote partnership with state Department of Education				X
4. Support partnerships with school-based health centers and community health centers				X
5. Support survey through Department of Education to monitor school policies across the state				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

FHS staff continue to broaden partnerships with school-based health centers to promote healthy eating and active living among the students, complement new school policies in nutrition and activity, and encourage and facilitate implementation of these policies. Staff nurture partnerships with the State Department of Education and the DPH Nutrition, Physical Activity and Obesity Prevention Program (NPAOP).

The NPAOP provided funding to (including but not limited to): (1) CitySeed who are working with the New Haven Food Policy Council to review federal, state, and local policies that affect the ability of public school districts - like New Haven's - to serve fresh, healthy school meals. The goal is to increase student consumption of fresh cooked foods and fresh fruits and vegetables while decreasing consumption of processed foods served in New Haven schools; (2) Ledge Light Health District who are partnering with the Town of Groton Parks and Recreation to construct an "all inclusive" playground that will increase opportunities for low income children and their families to be physically active and is suitable for those with disabilities and or special needs; (3) Northeast District Health Department which implemented a nutritional educational program targeting 4th, 5th and 6th graders in Putnam, Thompson and the Putnam Youth Group (approximately 500 students) utilizing the USDA MyPyramid.

c. Plan for the Coming Year

The (NPAOP) with initiated a contract to test and evaluate two healthy eating and two physical activity curricula in Connecticut public elementary schools. Next year a contractor will conduct this evaluation in both an urban school district and a suburban/rural school district. Four intervention schools and one control school will be used in each urban and each suburban/rural school district for a total of ten schools participating in the evaluation. Results and recommendations will be provided as part of the effort to promote the participation of the school districts in the prevention of childhood obesity and the promotion of good nutrition.

Staff will partner with the SDE and local school districts to promote physical exercise and nutrition programs in schools statewide. Staff will work with other state agencies, such as the Department of Transportation on the Safe Routes to School Stakeholders Committee. This program develops the state infrastructure to enable and encourage school children to walk and bike to school. The committee is charged with developing a plan to allocate the funding to communities in CT.

The "Captain 5 Day program" delivers nutrition education messages (eat 5 a day, fruits and vegetables are good for you/make you healthy/grow strong, etc.) and messages promoting the importance of physical activity. This activity will be implemented with children in School Readiness and Head Start classrooms. Lessons provide children with interactive experiences in healthy eating and active lifestyles that, when cemented early in life, can be continued throughout childhood and into adolescence and adulthood. Nutrition education workshops for teachers and staff increase the ability to provide quality nutrition education to preschoolers and their families. Preschoolers' families are reached through classroom messages carried home as well as a menu of direct and indirect nutrition education opportunities for parents and caregivers.

Program staff will provide technical assistance and manage Preventive Health and Health Services Block Grants awarded to 13 Local Health Departments/Districts to promote physical activity and healthy eating in community and school settings.

State Performance Measure 6: *Percent of infants born to women under 20 years of age receiving prenatal care in the first trimester*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				70.5	70.5
Annual Indicator			69.8	69.8	
Numerator			1984	2002	
Denominator			2842	2867	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	70.7	70.9	71.1	71.3	71.4

Notes - 2007

CY 2007 data are not available.

Notes - 2006

Source: CTDPH Vital Statistics CY2006 final data.

Notes - 2005

Data is from DPH Vital Statistics, Calendar Year 2005. Updated in this year's application from last year that used 2004 data.

a. Last Year's Accomplishments

This measure was not met. Data for both CY2005 and CY2006 indicate that 69.8% of women under 20 years receive prenatal care in the first trimester (lower than the goal of 70.5%). Similar to the poor outcomes for NPM#18 where infants born to mothers of all ages are not meeting the goal of receiving prenatal care in the first trimester (CT=85.8% vs. a goal of 87.8%), further investigation into the factors contributing to these poor outcomes is needed.

Comadrona provided outreach and intensive case management to enroll 100% of its pregnant women in the first trimester. Through its community-based networks, clients were identified and referred to prenatal care providers.

Healthy Choices for Women and Children provided outreach and intensive case management to pregnant women, who by virtue of a history of substance use, may encounter barriers in obtaining early prenatal care. The program educated clients on the benefits of early pregnancy care.

Right From The Start provided support, information, advocacy and linkage to early prenatal care for pregnant teens. It coordinated its activities with school and community providers to identify and enroll clients in the program and refer to appropriate prenatal care providers.

Results from Round 2 of the CT PRATS survey were presented to DPH staff, external partners, and stakeholders. Staff also filled multiple requests for data resulting from the survey. Due to several limitations of the data from Rounds 1 and 2 of PRATS, data have been used to compliment existing data; further analytic analyses were not pursued. Rather, additional analyses of the data have begun that will inform Round 3 of the survey, which is currently planned to begin in 2009.

Planned Parenthood of CT provided pregnancy testing, reproductive health education, counseling and prenatal linkage to community providers to promote first trimester care. PPC also provided linkages to health related programs such as WIC and Healthy Start to support compliance with prenatal care schedules.

Using a confidential and de-identified case approach, the FIMR program used record abstraction

and home visits to identify issues such as a lack of availability of perinatal services and lack of client knowledge which may contribute to perinatal deaths. An MOA was executed with the University of Connecticut to begin the transition to the statewide approach. While it was anticipated that the five FIMR sites would end their contracts as of 6/30/07, the legislature provided State funding to continue these programs through June 30, 2008.

In collaboration with the Federal New Haven Healthy Start, administered by the Community Foundation for Greater New Haven, DPH launched a campaign addressing infant mortality in the African American population. The campaign included the message of the importance of seeking early prenatal care services, which was disseminated via television, radio, and poster advertisements.

SBHCs provided outreach to identify pregnant women and age-appropriate reproductive health education, counseling and referrals of women to other related programs such as Healthy Start and WIC. Although the clinics are not considered primary sources of prenatal care for pregnant teens, they prioritize the need to assist and support pregnant teens in accessing early prenatal care. Many sites utilize a team approach (APRN and social worker) to support pregnant students.

A reproductive health workgroup, comprised of diverse stakeholders, was convened to address the reproductive health strategy outlined in the State Adolescent Health Strategic Plan.

WIC emphasized and promoted early enrollment into their program and provided screenings and referrals to prenatal care providers. The program continually focuses on 1st trimester enrollment to low-income pregnant women.

CHCs, through a comprehensive care model, provided early identification of pregnant women and continuous prenatal care. Selected centers (10 of 13) provided obstetrical services on site. Smaller centers referred clients to other local prenatal care providers. Two 6-month pilot programs to screen for perinatal depression were conducted at 2 CHCs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users)		X		
4. Provide support, information and advocacy to pregnant teens	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers	X			
6. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
8.				
9.				
10.				

b. Current Activities

Comadrona and RFTS were ended and replaced with the Case Management for Pregnant Women program. The programs provide linkages to prenatal care services.

Epidemiology Unit staff continue preparations for Round 3 of the CT PRATS survey. This work includes refining the sampling plan based upon analyses of respondents versus non-respondents from the previous 2 surveys; identifying an appropriate birth cohort; identifying an improved methodology for drawing the sample; finalizing survey content; and investigating the use of Pegus Research, Inc. as the contractor to administer the survey (since they completed the first 2 rounds of PRATS).

Family Planning provides reproductive health care to outreach and refer pregnant women to community-based programs to promote early prenatal care.

FIMR was enhanced by the development of a statewide surveillance system. DPH is collaborating with the University of Connecticut to conduct the statewide surveillance program. The legislature continued to fund the FIMR program to the five original FIMR sites.

SBHCs network and advocate for clients with school and community providers to promote early identification and entry into prenatal care.

Community Health Centers encourages women of reproductive age to seek early and regular prenatal care. As a result of the pilot programs to screen for perinatal depression, two CHCs implemented this protocol to continue screening pregnant clients for perinatal depression.

c. Plan for the Coming Year

Comadrona and RFTS were ended and replaced with the Case Management for Pregnant Women program. Three contractors were selected through an RFP process to provide comprehensive case management to pregnant and/or parenting women to address perinatal health disparities with emphasis on African-American/Blacks, Hispanics, teens, and adolescent fathers. The programs will provide linkages to community based providers for prenatal care services and the New Haven program is co-located in Wilbur Cross High School. Pregnant teens are referred to the program and are provided with information about the importance of prenatal care and parenting.

The FIMR program has been complemented by the addition of a statewide surveillance system with the purpose of identifying health related issues regarding fetal and infant mortality, to better understand what motivates and mobilizes communities to take action to prevent fetal and infant deaths, and to initiate statewide interventions to prevent fetal and infant deaths including the promotion of early entry into prenatal care. The five FIMR programs will provide prevention and intervention strategies to help reduce fetal/infant mortality in their communities.

A new Infant Mortality campaign (television advertisement) is being developed with community partners and a marketing advertising vendor. Partners include the federal New Haven Healthy Start Program and the Hartford Health Department. The advertisement will focus on the African American community and encourage early entry into prenatal care.

DPH will work the DSS to link Birth-Medicaid data files (2000-2005 birth cohorts linked, 2006 birth cohort recently sent to DSS for linkage). Subsequent analyses could then be conducted that may identify demographic populations that are at risk for not seeking early prenatal care. Strategies could then be developed to address these at-risk populations.

The FHS plans to complete the triple match with the WIC data as the WIC data becomes available. FHS found through an analysis of the 2000 linked Birth-WIC-Medicaid data that WIC enrollment at least 12 weeks before delivery had a protective effect on low birth weight outcomes

in CT, controlling for multiple characteristics known to be predictors of adverse birth events. Similar analyses will be completed that may provide information related to the early entry into prenatal care.

State Performance Measure 7: *Percent of CYSHCN who receive family-centered, community-based, culturally-competent, comprehensive, coordinated family/caregiver support svcs incl. respite in the Regional Medical Home System of Care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				26.4	54.1
Annual Indicator				44.9	86.4
Numerator					4037
Denominator					4675
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	89.8	91.6	92.5	93	93.2

Notes - 2007

The numerator is based on a full year of the number CYSHCN served by the regional medical home sites. The denominator is the estimated number of CYSHCN that the regional medical home sites were expected to serve.

The annual performance objectives for 2008-2012 were updated to reflect this more recent data.

Notes - 2006

The annual indicator for FY2006 reflects the first year of a new methodology to collect data on CYSHCN receiving respite. These data attempted to capture information from the then existing five Regional Medical Home Centers.

a. Last Year's Accomplishments

Due to the change in data source, it is unclear whether this measure was met or not. The data used will be readily available next year when comparisons can be made for trends. A search for national data was unsuccessful for comparative purposes.

Data for FFY 2007 reflects a change from the Docsite database to an Access database. The Regional Medical Home Support Center (RMHSC) System of Care for CYSHCN provided family/caregiver support services that covered a full range of needs including medical, educational, and community supports and linked information through the families medical home. RMHSC's continued to distribute direct and camp respite funds to Connecticut children and youth with special health care needs.

DPH monitored, enhanced, and revised the statewide respite system available through the RMHSCs. DPH distributed the Get Creative About Respite manual through community activities and began the process to identify funding for additional copies of the manual. DPH staff edited, printed and disseminated "Directions: Resources for Your Child's Care," an information organizer for families, available both in hard copy and electronically (through the DPH web site) and includes sections on Medical Home, health plan information, transition, connecting parents and families, and more.

DPH released several RFP's to expand the medical home concept throughout CT. This helped to assure more families have access to a family-centered, community-based system of care model. Contractors provided services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. A

memorandum of agreement was in place with another state agency to assist with transitioning the program from the RMHSC model to the new structure effective July 1, 2007. A "kickoff" meeting was held to orient providers on collaborations and expectations for the new service system.

National Lifespan Respite Care Act of 2006, public law 109-442 authorized competitive grants to Aging and Disability Resource Centers in collaboration with a public or private non-profit state respite coalition or organization to make quality respite available and accessible to family caregivers regardless of age or disability. The law allows grantees to identify, coordinate and build on federal, state and local respite resources and funding streams, and would help support, expand and streamline planned and emergency respite, provider recruitment and training, and caregiver training.

Connecticut proposed legislation that identifies the Department of Social Services as the agency to contract with nonprofit organizations that promote the purposes set forth in the Lifespan Respite Care Act of 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services		X		
2. Capture and document care coordination activities		X		
3. Distribute "Get Creative About Respite" and "Directions" manuals, and family directed respite funds	X			
4. Provide forums for sharing of "Get Creative About Respite" manual and other community support solutions		X		
5. Work with state agencies, community providers, and families to further expand the sharing of community support solutions				X
6. Follow national Lifespan Respite legislation for possible funding opportunities				X
7.				
8.				
9.				
10.				

b. Current Activities

DPH contractors support medical homes in providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs. Contract grantees capture data related to care coordination activities covering a full range of needs including medical, educational, and community supports.

DPH contracts the Connecticut Lifespan Respite Coalition to implement respite protocols and distribute respite and department approved extended service funds for Connecticut families. Respite care includes processing of requests for respite care provided in or out of the home for the purpose of providing relief to the family/caregiver from the daily responsibilities of care provision for a child or youth with special health care needs. These services are family-directed with provider and location of the respite services of the family's choice. The contractor works with state agencies, community providers, and families statewide to further distribute the Get Creative About Respite and Directions manuals and provides forums to share local community support solutions. During the first six months of the current contract year, 229 families each received \$500 of respite funding. This was a change from the previous policy of a \$500 maximum per

child to \$500 per family regardless of the number of CYSHCN. As of 1/1/08, 1,034 families are on a respite waiting list.

c. Plan for the Coming Year

DPH contract grantees will fulfill their responsibilities by supporting medical homes in providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs. Contractors will capture data related to care coordination activities covering a full range of needs including medical, educational, and community supports.

DPH contractors will implement respite protocols and distribute respite and department approved extended service funds for Connecticut families. Services will be family-directed with provider and location of the respite services of the family's choice. The contractors will work on further distribution of the manuals and forums to share solutions.

DPH will promote the family-centered Medical Home concept in Connecticut including statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs, and link these children to medical homes and family support services.

Family support services will provide assistance and culturally appropriate education to families of CYSHCN that enables families to acquire skills necessary to access needed medical and related support services. Families will learn to link to needed supports and become empowered to be competent supporters for their children.

Advocates for the Lifespan Respite Care Act of 2006 (HR 3248) will strive to have authorized the \$53.3 million allocated for FY09 in the Labor, Health and Human Services, and Education funding bill. DPH will follow the status of the Act for possible funding opportunities.

State Performance Measure 8: *Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in "Caring for Our Children".*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2008	2009	2010	2011	2012
Annual Performance Objective	0	0	0	0	0

Notes - 2007

CY2007 data are not available.

Notes - 2006

This SPM is now labeled developmental as CT is working to implement methodology to collect data to measure the percent of day care centers who have on-site health consultation by an

appropriately qualified health professional.
CY 2006 data are not available.

Notes - 2005

This SPM is now labeled developmental as CT is working to implement methodology to collect data to measure the percent of day care centers who have on-site health consultation by an appropriately qualified health professional.

a. Last Year's Accomplishments

This measure does not have any available data yet. Data should be available in 2009.

DPH plans to meet with the Radon Program to develop a mechanism to extract the needed information from the inspection forms necessary for the Radon Program as well as for this SPM. DPH staff will meet with the Day Care Licensing Section to check on their progress toward computerizing the inspection forms.

The Title V Director, or her designee participated on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure. The progress towards meeting this measure, and the accompanying activities was discussed at the CT Early Childhood Partners quarterly steering committee meeting, to seek additional input from steering committee members.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with the Radon Program to review the collected Day Care Licensing inspection forms				X
2. Enter forms into an Excel spreadsheet with the assistance of the Radon Program				X
3. Review data looking to identify Child Day Care Centers that were non-compliant on the inspection forms on maintaining a health consultation log				X
4. Establish baseline on the compliance of maintaining the health consultation log at Child Day Care Centers for future comparison				X
5. Participate on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure				X
6. Discuss progress towards meeting this measure at the CT Early Childhood Partners quarterly steering committee meeting, to seek additional input from steering committee members				X
7.				
8.				
9.				
10.				

b. Current Activities

During the 2007-8 grant year, FHS staff had in-depth conversations with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to

conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."

FHS clerical support staff assisted the Day Care Licensing Program with the data entry of a backlog of health consultation reports into the database on a periodic basis to assure the availability of information for this performance measure. A query of the data was put on hold as the Day Care Licensing database was also a DPH database prioritized to be migrated to the PHIN platform. FHS staff were informed in March 2008 that the information needed for this measure will be available after the migration.

c. Plan for the Coming Year

FHS will monitor the progress of the migration of the Day Care Licensing database to the PHIN platform. Once the database is functional, we will request a standard data report to obtain the information for this measure.

FHS is considering whether to eliminate this measure with the difficulty in obtaining the needed data, as well as, other Region I states inability to obtain any measurable data. CT will bring up in discussion with the Region I states.

E. Health Status Indicators

Health Status Indicators

Health Status Indicators

Health disparities have been a focus within DPH including a sub-workgroup within the PHI Branch in which FHS is located. There are a number of health status indicators that substantiate our need to focus on this issue. An example of this is that 22.75 African American infants and children 0-19 live in a household headed by a single parent vs. 7.3% for all races. Among all racial groups, the African American 0-19 year olds have the highest percent of families on TANF (14.3%) versus 5.8% across all races. African American 0-19 year olds also have the largest dropout rate among the different racial groups at 2.6% vs. 1.8% for all races.

These disparities hold true for the Hispanic population as well. The CT Hispanic population of infants and children 1-19 live in a household headed by a single parent; 16.1% of these families are on TANF; and have a dropout rate of 4.4%

Birth outcomes data in CT show an increase in both the percent of live births weighing <2500 grams (both non singleton and singleton births), as well as an increasing % of live births weighing <1500 grams. One might attribute the increasing percentages to the number of women who are opting to utilize assistive reproductive technology and have multiple births. Realizing there is a need to address LBW and VLBW, staff has developed "A Strategic Plan for Addressing Low Birth Weight," which includes both short and long term strategies and resources required to implement these strategies. There has also been an increase in the WIC enrollment, which is now at 56,000. CT analyzed the outcome of a 3-way data linkage (WIC, Birth and Medicaid files) and determined that enrollment into WIC at least 12 weeks prior to delivery was a protective factor against delivering a low birth weight infant. This gives us supporting data to more closely monitor if pregnant women are being linked and enrolled into the WIC program. Analyses have also found a gap for women who are eligible for co-enrollment in HUSKY A and WIC (33% of women enrolled in HUSKY A were not co-enrolled in WIC.). This presents an opportunity to encourage WIC staff

to ensure potential women eligible for HUSKY A get enrolled.

This information, (increased percent of VLBW and LBW infants) coupled with the decreased percentage of infants born to pregnant women receiving prenatal care in the first trimester (NPM #18) leads one to conclude that the lack of early prenatal care may have a causal effect on the increased VLBW and LBW infants. A thorough assessment of CT's perinatal systems of care is warranted and resources must be allocated (multi-agency) to turn the curve of these indicators. A healthy baby begins well before a woman becomes pregnant, and preconception care has to become a priority. This may be more realistic given the new Charter Oak Health Care Plan for uninsured adults, a voluntary health plan that includes monthly premiums and annual deductible based on household income. Unlike many other health plans, the Charter Oak Plan covers enrollees with pre-existing conditions. Staff has also started to address preconception/interconception care by working collaboratively with the Hartford Health Department on their preconception technical assistance grant from CDC/CityMatCH. We have also included the need to screen women for interconception care as part of the contract language for the DPH's new case management programs for pregnant women.

CT has made positive progress by achieving a steady decline in the rate of unintentional injuries (those due to motor vehicle crashes) in children <14 years of age. This may be primarily contributed to the new laws regarding the use of child safety seats, the community-based trainings conducted on the proper use of child safety seats and more stringent laws for 16- and 17-year-olds. The data for unintentional injuries due to motor vehicle crashes among youth aged 15-24 is unstable over the past 4 years. CT has recently mandated stricter teen driver laws which require: (1) youth be at least 16 prior to obtaining their driver's permit, (2) that parents must attend certain classes with teen drivers, and (3) once a teen obtains his/her license, they must adhere to a "graduated" license process.

The data for Chlamydia is unstable in both the 15-19 and 20-44 age groups for women. What is clear is that the percentage of Chlamydia is higher in African American women than in other known races. In 2007, for ages 15-19, 27.2% of the cases were Black females, 14.0% Hispanic females, and 10.2% White females (30.6% to females of other or unknown race).

CT must take a good look at the health of African American/Black females, and assure access to health insurance, make linkages to primary care providers for preconception and interconception care, ensure early entry and ongoing prenatal care for pregnant women, and co-enrollment in WIC and HUSKY A if eligible.

The anticipated 2009 PRATS survey of women's attitudes, behaviors and experiences before, during and after pregnancy will also provide useful information to form a more comprehensive picture of perinatal care in CT.

Challenges and barriers to addressing the health status indicators include:

(1) Access to current data. As previously discussed, CT is not a state that has PRAMS funding and has to continuously seek funding to conduct the point-in-time PRATS surveys. In addition, we are making more headway with obtaining vital records data in a timelier manner. (2) Coordination of services. Although CT is a relatively small state, there are many programs that impact pregnant women, infants and children. There is a need to improve collaborations among the various programs, and ensure a seamless system of care for those utilizing the health care delivery system. (3) Delivery of inconsistent message to consumers. We have to develop a consensus with health care providers regarding preconception care. On one hand we are encouraging women to engage in a preconception visit, but on the other hand, some providers are indicating to make an appointment when they are pregnant. This challenge can be addressed with ongoing dialogue and a mutual understanding with health care providers. (4) Social factors. Poverty, access to affordable housing, cultural influences, educational attainment and other social issues impact whether or not and how frequent consumers seek care. (5) Need to adopt the lifecourse perspective. There has to be a paradigm shift and more focus on the lifecourse

approach to health issues. DPH will continue to promote the lifecourse approach in its MCH programs. (6) Lack of adequate funding. There needs to be an infusion of funding to adequately address the perinatal issues that are raising the red flags in CT. State funding has been level, and in some instances, reduced and federal funding has also been reduced. This (decrease in programs/services) compounded with the current economic climate, again, places those most vulnerable in an even more challenging situation.

F. Other Program Activities

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Abstinence-Only Education Initiative supports a community-based abstinence-only education program in Bridgeport CT, to promote abstinence from sexual activity among racially and ethnically diverse, nine- to 14-year-old males and females.

/2008/Connecticut no longer receives funding for Abstinence Only programs.//2008//

The asthma program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The asthma program and FHS staff has collaborated to assess Title V program data and activities to develop interventions for children diagnosed with asthma.

/2008/The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The Program collaborated with the FHS staff to assess Title V data for children with a diagnosis of asthma and develop a baseline that can be used to evaluate effectiveness of future interventions.//2008//

Breast and Cervical Cancer Early Detection Program provides screening and diagnostic services through 18 primary health care facilities and over 100 subcontractors throughout the state. The program provides case management and community-based education and outreach targeting medically underserved women.

Childhood Lead Poisoning Prevention Program operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing.

/2008/Has been renamed the Childhood Lead Poisoning Prevention and Control Program and lead poisoning prevention activities are now centralized in the Regulatory Services Branch.//2008//

/2009/CLPPCP also provides regulatory oversight and consultative services, and supports two Regional Lead Treatment Centers. The major goal is to eliminate elevated blood lead levels (>10mcg/dL) in children less than 6 years of age in CT by 2010.//2009//

Chlamydia Infertility Prevention provide free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics.

/2008/Free services are available at clinics to under and uninsured females, particularly those under 25 and sexually active, and their partners.//2008//

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

Healthy Child Care CT more than 50 organizations that play a key role in the planning and delivery of child care and health care for children and families. Leadership is provided by a collaborative effort of DPH, DSS, and the Children's Health Council through the CT Head Start State Collaboration Office. /2007/This program will be reported with the Early Childhood Program.//2007//

/2009/CT Immunization Program activities are designed to prevent disease, disability and death from vaccine-preventable diseases in children and adults. Funding is provided to 11 health departments, 4 health districts and 1 regional community provider to conduct activities to raise immunization rates and the Vaccines for Children provides free vaccines to over 600 health care providers to eliminate cost as a barrier to receiving immunizations. The CT Immunization Registry and Tracking System permanently tracks and records all CT children's immunizations given in childhood.//2009//

Intimate Partner Violence prevention is currently addressed at hospitals statewide by providing training to health, mental health and public health professionals, paraprofessionals and students statewide regarding intimate partner violence issues, screening and appropriate referral. Efforts are underway to address intimate partner violence with the women's correctional institute (York Correctional Institute).

/2009/IPV activities are now conducted at YCI; training is offered to both staff and inmates.//2009//

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

/2007/Primary Care Services Resource Coordination and Development Grant activities coordinate local, state, and federal resources that contribute to primary care service delivery and workforce issues in the state to meet the needs of CT's vulnerable and high risk populations.//2007//

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services ensures the provision of direct services for victims of rape and other sexual assaults throughout the state. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts.

/2008/Staff will be convening a committee to develop a statewide sexual assault prevention strategic plan.//2008//

/2009/The statewide Sexual Assault Prevention Planning Committee has been convened.//2009//

WIC serves approximately 55,000 participants in CT. They include low income pregnant, breastfeeding and postpartum, non-breastfeeding women, as well as infants and children up to five (5) years.

/2009/WIC provides nutritious food, health education and referral services to eligible

individuals.//2009//

/2008/WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) incorporates cardiovascular disease screening and intervention services into the healthcare delivery system at nine contracted health care provider sites.//2008//

/2009/The state's MCH Information and Referral Service is administered by the United Way of CT/2-1-1 Infoline. The toll free line is available 24 hours/day, 7 days/week;multilingual call specialists and TDD access is available.

In CT, 2-1-1 is the single point-of-entry for many programs, including the CYSHCN Program & the perinatal depression screening provider consultative line. 2-1-1 is certified in crisis intervention by the American Association of Suicidology. The majority of CT's public awareness campaigns include 2-1-1 so that the public has easy access to an established infrastructure of information & referral services. United Way has enhanced its website to allow visitors web-based access to the directory of services that would be accessed to callers. In collaboration with the DPH, 2-1-1 has posted health related information on Infoline's E-Library which is accessed via its website. DPH & Infoline have collaborated to include information on sickle cell disease/trait, perinatal depression screening & other topics. United Way staff co-facilitates the MCH Advisory Committee & was a grant partner on the DPH's recently submitted HRSA First Time Motherhood grant application.//2009//

G. Technical Assistance

During the FFY 2007, CT was fortunate to receive technical assistance in three areas:

1. Population addressed- Children: July 2007, the DPH supported a full day forum at our State Capitol where Dr. Richard Wasserman, Professor of Pediatrics at the University of Vermont and National initiative for Childrens' Health care Quality board of directors member, and Judith Shaw, Executive Director of the Vermont Child Health Improvement Program, shared their expertise concerning the VCHIP; the visit supported the pending replication of such a program in Connecticut.
2. Population addressed - Women's Health: June 2007, A consultant was retained to provide expertise in working with the Title V MCH Director and the Hartford Health Department to develop an Action Plan for Addressing Preconception Care in the City of Hartford. The HHD received a technical assistance grant from CDC/CityMatCH to begin to assess preconception and interconception care. As a result of this TA, the HHD will be convening a summit this fall, to release the plan and to develop action steps in implementing the recommendations in the Action Plan. This work also nicely laid the foundation for the recently submitted "First Time Motherhood" HRSA grant.
3. Population addressed-CYSHCN: December 2007, in collaboration with the United Way of CT, the DPH sponsored a day-long workshop on transitioning for children and youth with special health care needs and their families. The DPH has not had a formal relationship with, or included in previous workshops members of Kids As Self Advocates (KASA). Members of KASA were active panel participants during the workshop and their participation was extremely critical to the success of the workshop. At the conclusion of the workshop, the CT KASA members indicated that it was a great opportunity for them as well, and looked forward to the opportunity to present information from a youth's perspective in the future.
4. Population addressed - Fathers: June 2008, - the CT DPH will work with Doug Edwards (Expert Consultant) who is the Executive Director of "Real Dads Forever." Mr. Edwards is a family educator, Certified Family Development Credential (FDC) Trainer and a very active member of the state MCH Advisory Committee, which is co-convened by the Title V Director and the United Way of CT 2-1-1. The recommendations from the State Perinatal Plan includes the

development of a curriculum for fathers that includes communication with the mother, strategies to reduce stressors in the relationship, impact of nutrition and lifestyle and the impact on future or existing pregnancies.

Without access to the MCHB TA, many of the above collaborations would not have occurred. It is a wonderful opportunity to host events with other Region One states, and CT DPH will continue to look for opportunities to network with, and replicate successful programs from our other Title V states and other community based agencies. In particular, we are pleased to be able to develop products that can be replicated in other communities.

//2009/ Technical Assistance requests for next year will focus on:

1. Population addressed-CYSHCN: - The DPH contracted community based medical homes have a varying degree of expertise in the utilization of data systems. We will focus on the ability to improve care coordination capacity and quantification of these services through better understanding and utilization of National Data Resource Center information.

2. Population addressed - CYSHCN:-- The medical homes funded by the CYSHCN program have formed a learning collaborative. The purpose of this collaborative is to address an identified challenge of coordination with sub-specialists. The TA will be used to provide consultation to the collaborative to help strengthen the care coordination system.

3.Population addressed-- CYSHCN:-- There are several small community based grassroots youth organizations that advocate on behalf on youth with special health care needs. TA is requested to convene a multi-agency/organization statewide workshop to empower more youth to take a leadership/advocacy role.

4.Population addressed -Women, Children, CSHNCN:-The technical assistance requested is to identify a process to systematically integrate screening for violence in all of the Title V programs.

5.Population addressed - Pregnant Women- Technical assistance requested is to address perinatal health indicators, systems review and identify key recommendations. //2009//

V. Budget Narrative

A. Expenditures

There were many overall factors that impacted the actual expenditures in comparison to the FFY2006 budget. More details specific to each of the Budget Forms are described below.

Form 3

For FFY2006, not all of the Federal Allocation was spent for several reasons, including staff moving to other positions, a delay in payment for contracted services, and a delay in filling other Title V funded vacancies.

Other sources of Federal funds were not fully expended in FFY2006. The Abstinence Education grant award period does not end until September 30, 2006, so funds have not yet been fully expended. Other federal funds were not fully expended because of a delay in payment for contracted services within the FFY2006 period.

Form 4

FFY2006 marked a change in services to CYSHCN. This was a transition year for CT, in that the use of two CYSHCN centers as the system of care was shifted to five Regional Medical Home Support Centers. The funds budgeted to this population group were not fully expended due to termination of 2 CYSHCN contracts.

The amount expended for "Other Populations" did not meet the budgeted amount due to DPH not spending as much funds anticipated on male/father activities as in previous years. The amount expended for Administrative costs in FFY 2006 exceeded the planned amount due to funds provided for storage and dissemination of MCH materials, and funding MCH related trainings.

Form 5

The amount exceeded for Population Based Services was due to more activities occurring in this population group. More of the newborn screening activities were undertaken.

An attachment is included in this section.

B. Budget

B. Budget

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CYSHCN (Medical Homes). These matching funds will total \$3,975,000 for FFY 2008. For FFY 2008, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total \$3,125,000 for FFY 2008. The Maintenance of Effort amount for FFY 2008 is \$7,100,000 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Pregnancy Related Mortality Surveillance, Fetal and Infant Mortality Review, Youth Risk Behavior Surveillance, and Family Planning. In addition to these programs, there are

several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY 2008. The federal allocation for FFY 2008 is \$4,803,010, which means that the State of Connecticut must match with at least \$3,602,257. Maintenance of Effort for FFY 2008 is in the amount of \$7,100,000, which is \$322,809 more than the required FFY 89 base of \$6,777,191.

Other federal grants received by the Family Health Section that serve the maternal and child population will include: Rape Prevention and Education, Intimate Partner Violence, Universal Newborn Hearing Screening, State Systems Development Initiative (SSDI), and ECP, CT's CECCS program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY2008 award amount, \$1,618,973 (34%) is allocated for Preventive and Primary Care for Children; and \$2,000,521 (42%) for the CSHCN program. There is an allocation of administrative costs of \$227,778 (5%) of the projected federal allocation to all programs.

In FFY 2008, the federal allocation is \$4,803,010 plus using \$615,603 of the carry forward from FFY 2006 funds for a total of \$5,418,613 of federal funding. When combined with the state funds of \$7,100,000 there is a federal-state block grant partnership total of \$12,518,613.

An attachment is included in this section.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.